stroschein

IN THE CIRCUIT COURT FOR THE
11TH JUDICIAL CIRCUIT IN AND FOR
DADE COUNTY, FLORIDA

GENERAL JURISDICTION DIVISION

CASE NO. 00-03153 CA 32

SUZETTE A. JANOFF,

Plaintiff,

vs.

PHILIP MORRIS INCORPORATED,
("PHILIP MORRIS U.S.A."),
R.J. REYNOLDS TOBACCO COMPANY,
LORILLARD TOBACCO CO., and
BROWN & WILLIAMSON TOBACCO CORP.,
Individually and as Successor
to THE AMERICAN TOBACCO COMPANY,

Defendants.
_____/

VOLUME 9

PROCEEDINGS BEFORE THE
HONORABLE LESLIE ROTHENBERG
on Tuesday, August 27, 2002
1:36 p.m. - 5:45 p.m.

APPEARANCES:

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I N D E X

PLAINTIFF'S WITNESS

E X H I B I T S

	Received
None.	

P R O C E E D I N G S

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(On the record at 1:36 p.m.)

THE COURT: You may be seated.

I've neglected to give you the designations for the rulings on Wurmlinger. I'll give that to you now. I have two sets here. This is plaintiff (indicating).

Now I had one question, and this is on the plaintiff's objections. Here is for the defense (indicating). And it's on the plaintiff's objections, and it's on Page 4 of those, and it's specifically Page 101, Lines 1 through 10.

Do you have yours with you?

MR. WILLIAMS: Wurmlinger?

THE COURT: Yes.

MR. WILLIAMS: Yes, I do, Judge.

THE COURT: And the reason I noted this one is that it's in the middle of an answer. It begins on Page 100, and it didn't make any sense to cut it off at that point.

So I didn't know whether you wanted to go back further or withdraw that objection or what the story is.

MR. WILLIAMS: That's 101, Line 1 through 10, right?

THE COURT: Correct.

MR. WILLIAMS: 101 --

THE COURT: 1 through 10 is a continuation of the answer beginning on 100, Line 17.

MR. WILLIAMS: I would go back to 101, Line 2 because the question by Mr. Molony is --

THE COURT: That's fine, instead of beginning on Line 1, just to pick that up on Line 2 instead.

MR. WILLIAMS: Yes, Judge.

THE COURT: All right. Because it didn't make sense to stop in the middle there. So it will be 101, Line 2 through Line 10.

Okay. That's sustained then.

MR. MOLONY: Excuse me, Your Honor, Line 2 through 10 on Page 101, the objection is sustained?

THE COURT: Correct: The rest of it stays in.

Okay. This is for you (indicating).

MR. MOLONY: I see on defendants' objections page, with reference to Page 51, Line 1 through 52 --

THE COURT: No, ignore that.

MR. MOLONY: Ignore the question.

THE COURT: Yes. Yes. That's when I started to go through those -- believing they were the objections, not the designations. Those are just designations.

MR. MOLONY: Okay.

THE COURT: Those are aren't objections. They are above it.

MR. MOLONY: And the rulings are next to those.

THE COURT: Correct. Those question marks are meaningless. I started to mark them, and I whited-out my markings and I forgot to white out those question marks.

MR. WILLIAMS: Your Honor has not yet ruled on the plaintiff's objections though, right?

THE COURT: Yes, that's what I just handed you, the long forms that we just talked about, plaintiff's objections to the cross designations. That's your handwritten

form.

MR. WILLIAMS: Yes, this one (indicating).

THE COURT: That's it. Underneath each of those, you'll see S's and O's.

MR. KODSI: O stands for overruled; S stands for sustained.

THE COURT: Thank you.

Now as for -- let me ask you this. Now for tomorrow you've told the defense which witnesses you intend to call already, correct?

MR. UPSHAW: Not quite.

THE COURT: Not quite.

MR. UPSHAW: No. We have a list of remaining witnesses, but we don't know who is coming between tomorrow and Thursday.

THE COURT: All right. Well, who --

MR. UPSHAW: I have no idea.

MR. WILLIAMS: We have -- tomorrow we will have Colette Cransdon and most likely the plaintiff, Chad, the son, and Carry Berdi, and that should take up the whole day.

THE COURT: Are there any issues that we're going to need to address before we

begin tomorrow on any of those witnesses?

MR. KODSI: At some point, Your Honor, I just ask that you reconsider at what point we're going to get cumulative testimony about smoking in the cabin.

THE COURT: I understand. So far I don't find it to be cumulative, but then I wasn't aware of all the witnesses that were going to be testifying.

MR. UPSHAW: And if my list is correct all we'd have left then for Thursday is the deposition of Ms. Wurmlinger, which you just ruled upon, the deposition of Hugh Fulton, video testimony, and if the plaintiffs intend to call her, Ms. Landman.

MR. HUNTER: And we do intend to call her and Houston, which the Court has already reviewed.

MR. UPSHAW: I'm sorry, it was Heyman. I apologize. And Houston.

THE COURT: I'll have to rule obviously on the -- your objections to Landman. Now actually on that, I have a note here, I've reviewed the defendants' motion to exclude her as a fact witness, but I can't very well

rule on this without knowing what she's exactly going to testify to.

Do you have a copy of her deposition?

MR. REILLY: We'll provide it to you today, Your Honor.

THE COURT: If you can get that to me, I'm going to need to review it.

MR. HUNTER: Bear in mind what Mr. Reilly asked her about and what I intend to ask her on the witness stand may be different things. I do think that we need to -- I'm going to offer a lot of documents, company documents, and that is something that is going to take some time outside the presence of the jury.

THE COURT: Okay. What I'd like to do then is address the objections to her testimony tomorrow after hours. We're going to be doing Mr. Weinstein's motion -- or his issue.

We'll address the Landman objections, and I think there was another area that we were going to also address tomorrow. Let's just plan on spending the time tomorrow night to go over all these other objections and any

other public records objections.

I think that would be an appropriate time to do it too, especially before the testimony on Thursday of these depositions, Wurmlinger, Fulton, and Houston.

MR. REILLY: Judge, here is Ms. Landman's depo.

THE COURT: Great.

MR. REILLY: And I don't know if it's been supplied to your chambers yet or not but we have a reply to Mr. Weinstein's position.

THE COURT: No, I haven't received a response yet. I have his that was delivered yesterday, but that's all I have so far.

MR. REILLY: We'll give it to you today.

THE COURT: Okay. Then tomorrow what I propose doing is we'll bring the jury -- so are there are issues we're going to need to address in the morning tomorrow before the testimony.

MR. UPSHAW: I'm not sure. I guess if we start with Ms. Cransdon -- I'm not sure if that was the order or not.

MR. WILLIAMS: I'm not sure on the

order.

THE COURT: So nothing --

MR. UPSHAW: Everybody has been addressed, the plaintiff, Chad, Ms. Cransdon, and Berdi. I think those have all been addressed.

THE COURT: Okay. We'll start tomorrow then at 9:45. That should give everybody an opportunity to beat the traffic a little bit and still start early to accomplish enough.

Now I'm going to take a recess after about an hour and a half of this videotape. We'll give the jury a 15-minute recess and then re-seat them and conclude that testimony today.

MR. HUNTER: Judge, there will be a tape change in an hour and 37 minutes.

THE COURT: That would be perfect.

THE BAILIFF: Rise for the jury, please.

(Whereupon, the jury entered the courtroom.)

THE BAILIFF: Anybody have a pen? Needs one?

Also your phones, folks.

THE COURT: Thank you. You may be seated. For the record, the jury is now in the courtroom.

Mr. Hunter, you may call your next witness.

MR. HUNTER: Yes, Your Honor, at this time we would call Dr. Mariel Stroschein by videotape.

THE COURT: Let me explain to you what we're going to do with this next videotaped testimony.

We're going to play it until the end of this tape and then take a 15-minute recess while we're changing tapes, and then we'll conclude that testimony after the break, and that will be all that we'll do today.

Starting tomorrow, we're going to begin at 9:45 in the morning, so this will be the only testimony, but it's rather lengthy and we'll give you a break in the middle of it. All right. You may proceed.

(The judge left the courtroom.)

(Thereupon, the videotape deposition of MARIEL STROSCHEIN, M.D., was played to the jury as follows:)

DIRECT EXAMINATION

BY MR. WILLIAMS:

Q. Would you please tell us your full name and your professional address?

A. Mariel Stroschein,

[DELETED]

Q. Are you a physician?

A. Yes.

Q. Could you tell the members of the jury what kind of doctor you are?

A. I'm a board certified otolaryngologist, or ear, nose, and throat specialist.

Q. All right. You understand we're taking your videotaped testimony to be used in court in Miami in the case of Suzette Janoff versus these defendants, right?

A. Yes.

Q. Okay. It's my understanding it would be very difficult for you to come down to South Florida and testify given your schedule; is that correct?

A. Yes.

Q. All right. Doctor, could you please tell us, if you could at this time -- give us

a little benefit of your background. Tell us a little bit about your background, where you went to medical school and so forth.

A. I went to State University of New York/Downstate Medical Center in Brooklyn, New York, and then I did a surgical residency program for two years at Montifore Medical Center, Jacoby Hospital in the Bronx in New York, three years of ENT training at New York University Medical Center in Manhattan with a fellowship in otology/neurotology for one year.

Q. Okay. And in layman's terms what is an otolaryngologist?

A. That's the diseases, medicine, surgery of the ear, nose, and throat. We also deal with -- the title of the organization is the Academy of Otolaryngology, Head and Neck Surgery, which also deals with head and neck cancer and, you know, other tumors in the throat and neck, thyroid, carotid gland.

Q. How long have you been a licensed physician either in New York or in Arizona?

A. I got my medical license in 1984 after completing a year of internship and passing the national boards.

Q. Okay. And was that in New York?
A. In New York.
Q. All right. Does every ENT also perform a fellowship, or is that work that's over and above what's required?
A. That's beyond the requirements of the board certification.
Q. All right. And obviously we're here in Arizona, and no longer in New York. How long have you been practicing medicine here in Arizona?
A. Since 1989.
Q. All right. And do you practice by yourself or with a partner?
A. I'm in partners with Adam Prawzinsky.
Q. Do you have staff privileges in hospitals and in the community?
A. Yes. Currently I have privileges at Scottsdale Health Care, Shea Campus, and I have some consulting privileges at Meridian Point HealthSouth Rehab Hospital.
Q. Okay. You say -- are you a surgeon, Doctor?
A. Yes.
Q. So, in other words, if somebody

sustained an injury to the head, neck, nose, you would be someone who was called to take care of a patient like that?

VOICE: Form.

THE WITNESS: Certain injuries, yes, because the specialty also includes facial plastic surgery of the face, fractures, and lacerations. It's actually very varied, what it encompasses.

Q. (BY MR. WILLIAMS) Are you board certified?

A. Yes.

Q. Could you tell the members of the jury what board certification means?

A. It means that after completing my residency in ear, nose, and throat, at the time my residency included five years of post-graduate, after medical school, five years of surgical training and a -- in a certified residency program, and requirements for certain number of surgical procedures performed by me.

And the requirements for the board certification in 1988, when I took the exam was -- it consisted of a written and an oral

examination.

At the time the oral examination was required for -- not necessarily required for every individual. In other words, if you obtained a certain level on your written examination, you did not have to take the oral examination.

Q. Okay.

A. And it encompassed all aspects of ear, nose, and throat. It was an eight-hour test.

Q. And that's -- and after that, you become board certified in your specialty?

A. Yes.

Q. And I believe you said you've been board certified, what, since 19- --

A. '88.

Q. -- '88. All right.

Doctor, can you tell us what kind of practice you have here in Scottsdale? If you could tell us, do you do some pediatric work? Do you do adults, or how do you quantify your practice? If you can help us out.

A. The -- my practice encompasses very general ENT problems, all age groups. I would say about 30 percent children, 20 to 30

percent elderly patients, and the majority middle-aged adults.

And most of the type of problems that we deal with are the upper respiratory infectious problems, allergies, sinusitis, ear infections, tonsillitis.

Q. You say allergies. Do you have experience -- you're not an Allergist, correct?

A. No, but allergy practice is part of ENT training, and in the first two years of my private practice, I administered allergy testing and allergy treatments, immunotherapy.

Q. Let me direct your attention to Suzette Janoff, and I understand you have her chart next to you; is that right?

A. Yes.

Q. And please free to -- feel free to refer to your chart at any time you want to during the deposition, okay.

Is Suzette Janoff one of your patients?

A. Yes.

Q. Can you tell us when was the first time that you saw Suzette Janoff as a patient.

A. January 8th, 1992.

Q. All right. When she first came to see you, Doctor, did you take a history from her?

A. Yes.

Q. Is that a customary thing to do for physicians to take a history of the patient?

A. Yes.

Q. All right. Can you tell us what kind of history she gave you?

A. I had obtained records from her other doctor, and according to her history at the time of the first visit was that she was a flight attendant and had recurrent episodes of sinusitis and complained of symptoms with exposure to smoke on the airplane.

Q. You say you obtained records from another physician. Had she been treated by another physician, to your knowledge, for complaints of sinusitis?

A. Yes.

Q. And what -- do you know the name of that doctor?

A. Dr. Jack Weiss.

Q. Do you know -- did she give you a history of ever having had any surgery before 1992 for sinus or any type of sinus surgery?

A. No.

Q. Did the records that you obtained from Dr. Weiss indicate whether or not she had had a chronic sinusitis in the past?

VOICE: Form.

THE WITNESS: No, the notes from the other doctor just documented the several episodes of sinusitis. It seemed to be the only thing that she was treated for.

Q. (BY MR. WILLIAMS) Was that the extent of the history she gave you when she came to see you in 1992?

A. Yes.

Q. All right. What were her complaints when she came to see you, Doctor?

A. Sinus infection and drainage on the first visit.

Q. And you say the first visit was in January of 1992?

A. In January, yes.

Q. Okay. Did you perform an examination of the patient at that time?

A. Yes.

Q. And could you tell the members of the jury what your findings were?

A. Yes. On her ear exam, her eardrums were mobile. The significance of that was that I did not see any ear infection or fluid in the ears. And that her nose was very hyperemic, which means it was very red and inflamed and congested.

And there was also evidence in the throat of a cobblestone description of the back of the throat, which indicates that there was some irritation from drainage.

Q. In the back of the throat?

A. In the back of the throat.

Q. Okay. Did you form an impression or diagnosis at that point?

A. At that point, I felt that her rhinitis was upper respiratory and treated her with an injected steroid.

Q. And where did you inject the steroid?

A. Into the turbinate bones in the nose.

Q. Okay. I understand that you have -- you have a diagram next to you.

A. Uh-huh.

Q. And I'll refer to it so we can understand exactly what you're saying to us.

What exactly -- could you show us what

the turbinate of the nose is, Doctor?

A. Yes.

Q. First of all, before I ask you that, is that an accurate description of the internal organs or the nasal passages in the sinus?

A. What this is showing is a schematic of some of the sinuses, six of them, with the internal structures of the nose, as well as the ear and eustachian tube.

Q. Which is the eustachian tube in that photograph?

A. This tube right here (indicating) going into the back of the nose.

Q. All right. Why don't you tell us where you injected her at that point.

A. In this picture, this line down the center of the nose would be the septum, which divides the nose in half.

Along the side wall of the nose are three sets of turbinate bones which circulate the ear, the inferior, the middle, and the superior turbinate.

In this case, the inferior turbinates are what I was describing as being very hyperemic and congested, and I injected the

steroid into the tip of the inferior turbinate to reduce swelling.

Q. Okay. Is that a painful procedure?

VOICE: Form.

THE WITNESS: No, I anesthetize the nose before I do that.

Q. (BY MR. WILLIAMS) Okay. And what was the purpose of that particular procedure, Doctor?

A. Well, in general, the steroid will get absorbed into the body, so it will cause a decrease in inflammation throughout the nose, not just where I injected it, but along the eustachian tube and higher up where the sinuses will normally drain.

Q. Okay. Did you follow up with Ms. Janoff after that?

A. Yes, she was seen again on May 4th of 1992.

Q. So roughly four months later --

A. Yes.

Q. -- is that right?

And could you tell us what the reason was for that particular visit?

A. At that time, according to my notes, she

was having recurrent sinus symptoms with drainage that was discolored, greenish, complaining of her ears being blocked, and she was preparing to go on another flight.

Q. Okay. Is there a significance to you that the drainage was greenish?

A. Usually I consider that to be an infection as opposed to a clear drainage or no drainage at all.

Q. What did your examination on that date reveal?

A. Again, I noted that the lining of the nose was hyperemic or very red and congested, that the turbinates were enlarged. I found no fluid in the ears.

The eardrums moved well, suggesting no blockage of the eustachian tube, not a physical blockage. And, again, the throat was irritated as well.

Q. All right. And what was your plan at that point, Doctor?

A. She was prescribed amoxicillin, which is an antibiotic. She was given a nasal steroid inhaler to use in the nose once a day, and also I recommended for her to use

Neo-Synephrine, which is a topical decongestant, in the nose, for three days.

Q. The antibiotic that you prescribed, was she supposed to take that, what, five days? Ten days?

A. Typically -- and I can look back in my notes, it's three times a day for ten days.

Q. Okay. Do you know if her condition cleared up after the administration of antibiotics?

A. No.

Q. You don't know if. . .

A. (Shakes head from side to side.)

Q. When was the next time that you saw Suzette, Doctor?

A. Let me see.

The next page of my notes was from a year later, July 14th of 1993.

Q. Okay. Do you know if whether -- do you know if whether or not she had seen any other physicians between the last time you saw her in 1992 and July of 1993?

A. I don't remember.

Q. Okay. Let me ask you this question, Doctor: Had you attempted to determine the

cause of her sinus conditions by the second time that you saw her in 1992, or was that still up in the air?

A. No, I was pretty sure that it was due to the environment of the plane.

Q. Okay. You felt that by 1992?

A. Yes.

Q. All right. Let's go to 1993, the visit of July of 1993, and could you tell us why she came to see you on that occasion?

A. Again, she was complaining of green discolored drainage and had just returned from a long flight.

Q. And what did your examination on that occasion reveal?

A. I just made note of enlarged turbinates, and I -- again, the ear exam was not very remarkable, and I did not make any mention of any drainage on exam.

Q. Is that basically the same findings that you had in the past with Suzette?

A. Yes.

Q. All right. Was there a significance to you that, during that visit when she had this problem, she had just returned from a flight?

A. Well, that's why I mentioned it because it seemed to be pretty consistent with the flying.

Q. Let's go through the next visit, and I know this is somewhat laborious, but I'd like for the jurors to understand how many times she came to see you.

And would that be in October of that same year?

A. Yes.

Q. And can you tell us what her complaints were at that point?

A. At that point, she was complaining of nasal obstruction, continued recurrent sinusitis, pain and pressure.

Q. And what did you do for her on that particular occasion?

A. At that time, I made note of a blockage of the -- the area where the sinuses drain on the right side.

Q. What does that mean when you made note of that? What is the significance of that?

A. Well, it seemed that her symptoms were getting worse and that there was more evidence of obstruction, and that the

congestion was getting worse.

She was having more difficulty breathing and now I can see -- it seemed to me that the sinus was not ventilating properly.

Q. Okay. And ventilating, what, there was no exchange of air?

A. Yeah, if I can go back to the diagram?

Q. Sure.

First of all, what -- if you could tell us, what is the purpose of the sinus, or how do the sinuses work?

A. Well, the short answer is we don't know. The theory is that when you're born, a newborn head is much smaller, and there are no sinuses.

So there is a small out-pocket right here (indicating) which will form the future sinuses between your eyes and your cheek, and that as the skull and head enlarges, the bone hollows out to form these hollow cavities, which is pretty variable.

And the theory is that by doing that, the skull will be strong, protecting the facial structures, but yet it won't be too heavy that we can't hold our head up.

Q. Uh-huh.

A. And where the sinuses drain is in this one general area, high up in the nose (indicating). So even the cheek sinus here (indicating), which goes down to the teeth, will actually drain uphill.

And in the previous examinations, I was describing mostly nasal congestion down here (indicating), and now I'm making note of the fact that this area (indicating) seems to be blocked on the right side.

Q. And what would cause the blockage?

A. Well, chronic inflammation can do that because the normal opening is very small, and after a while, it can -- the inflammation may not be easily reversible and it just causes it to be chronically blocked and, therefore, the symptoms persist.

Q. Are you saying that the tissue or whatever is there gets inflamed to such degree that it prevents the sinus from draining outside the nasal cavity?

A. Yes, and then variations in pressure will cause the pain and pressure, whether it's infected or not.

Q. I noticed that from that diagram, the eustachian tube appears to also either traverse or go directly into that sinus; is that right?

A. No, this is misleading because the sinus is very far in the front of your cheek, and this (indicating) is actually towards the middle of your head, in the back of the nose.

Q. Does the eustachian tube in any way drain into the nose or vice versa?

A. In the back of the nose.

Q. Okay. You mentioned that you felt her condition was getting worse, and now we're talking, what, two years after the first time she saw you?

A. Uh-huh.

Q. Did you -- did you decide on a course of action or a new plan for her?

A. At that point, I recommended a CAT scan of the sinuses, and I made a recommendation of considering a septoplasty.

Q. What is a septoplasty, Doctor?

A. That's surgery on the septum of the nose to correct any deviations which might be causing some physical blockage to breathing.

Q. During your examination, did you notice

whether she had some deviations that were so sufficient that would obstruct her breathing?

A. I mentioned a deviated nasal septum. Now sometimes -- and I can't recall now exactly where it was deviated. Frequently, a septoplasty is a very common operation for a crooked septum, most often done for breathing.

When it comes to sinus problems, occasionally, we'll do surgery if the deviated septum is contributing to the sinus blockage.

Q. Okay. Were you able to tell at that point whether there was a deviation in the septum that would cause the blockage or contribute to the blockage?

A. It's a combination of the physical examination and the CAT scan --

Q. Okay.

A. -- to determine how much it's contributing.

Q. Did she go ahead and have a CAT scan, Doctor, to your knowledge?

A. Yes, I think so. Let me see.

Yes.

Q. And were you provided the report of the CAT scan?

A. Yes.

Q. And I'm assuming that a physician such as yourself relies on the reports from radiologists who read CAT scans?

A. Actually, no, I do not.

Q. You don't?

A. Nope.

Q. You look at your own films?

A. I read my own x-rays.

Q. Okay. Do you know if you had the chance to read your own x-rays in this case?

A. Yes, I made a note.

Q. Could you tell us what the findings were of the CAT scan?

A. On October 18th, 1993, I made a note of CT -- CB, which means concha bullosa, mucosal thickening, deviated nasal septum.

Q. Okay. Let's take each one of those individually. First of all, the concha bullosa, what is that?

A. A concha bullosa is a term used to describe the turbinate. The turbinate is also known as the concha, you know, after the shell --

Q. Right.

A. -- from that -- the normal curve to it.

Bullosa is referring to an air pocket. And it's not unusual to see a concha bullosa of the middle turbinate, which -- the easiest way to describe it is when the middle turbinate expands and forms its own little sinus.

So you can see it very easily on x-ray, not -- when you're looking at the nose, you can't normally tell. The turbinate will just look enlarged. When you get the x-ray, the CAT scan, you can see that there's air in the center of it --

Q. All right.

A. -- and it's hollow.

Q. Did you attribute the concha bullosa that was observed in the CAT scan to causing or contributing to cause her sinus infections?

A. Not exactly, because most of the sinus problems that I noted were on the -- well, the most recent one was on the right side where I saw a blockage. The concha bullosa was on the opposite side.

Q. Okay. So if the concha bullosa had been found on the right side versus the left side,

maybe your opinion wouldn't be the same?

A. Yes. Frequently the concha bullosa will form, and it may not -- it's something that may -- that may develop as an adult. It's variable. When they do enlarge, they typically will cause a blockage of that sinus opening on the same side.

Q. Can you have a concha bullosa that basically is asymptomatic, doesn't cause any type of blockage?

A. Yes.

Q. What about the second finding that you had, Doctor, the deviated septum, were you able to determine to which side was deviated and how much?

A. No. I made mention of it. Let me get back to my notes.

But typically a deviated septum is not diagnosed on the CAT scan because the CAT scan that we do is perpendicular to the septum, and -- in other words, you might be able to see a deviated septum on the CAT scan.

Usually you can tell easier by just visual examination, and if you don't see a

deviated septum on CAT scan, it doesn't mean it's not there.

Q. Okay. Was there an x-ray taken to rule out the deviated septum?

A. I know we -- there were x-rays done, but usually I don't do it for the septum. It's more for the anatomy of the middle turbinates and the sinus lining.

Q. Okay. Based on your findings of the CAT scan, did you have any plan -- did you formulate a plan for Suzette?

A. Well, I recommended surgery.

Q. And what kind of surgery was that?

A. Correcting the deviated septum and turbinate surgery, as well as endoscopic sinus surgery.

Q. What is an endoscopic sinus surgery?

A. The endoscopic sinus surgery is done to restore the natural function of the sinuses, to promote drainage. And we do the surgery by using the magnified telescopes in the nose. Everything is done through the nose.

And the difference in that surgery compared to surgery that was done in the past was we're concentrating on the area where the

sinus naturally wants to drain, and trimming down the turbinates, making them smaller to relieve any obstruction and congestion, and then making sure that the opening is clear of any inflammation or polyps.

Q. Okay. The polyps, what are polyps?

A. Polyps are basically the tissue that's formed from the inflammation of the lining of the sinus.

Q. Is there a difference, Doctor, between acute sinusitis and chronic sinusitis?

A. Yes.

Q. And could you tell the members of the jury what the definition is?

A. The strict definition is acute sinusitis is an infection that is self-limiting. In other words, someone will get sick, they'll have green or yellow or foul drainage.

They'll have pain and pressure. They'll be congested. It may be caused by a virus or a bacteria, and usually it will clear up within two or three weeks. Whether you take anything or whether you just let it run its course, it will usually go away.

When you have a problem that continues

for more than three or four weeks or just recurs over and over again over a period of time, then we call that chronic sinusitis.

Now a chronic sinusitis doesn't necessarily mean that there's an infection. When you do an x-ray, a CAT scan, because that's the preferred examination, a CAT scan will show inflammation in the lining of the sinus, and whether there is an acute infection or not, we would term that chronic sinusitis.

Normally the lining of the sinuses is so thin that it does not show up on the x-ray.

Q. Okay. Do you know if the CAT scan that was performed in 1993 revealed an inflammation of the lining of the sinus?

A. Yes.

Q. Is that yes, you know, or yes, it did?

A. Yes, it did.

And in my notes, I mention mucosal thickening. And that's the significance that when you see the lining of the sinus, then that is indicative of a more chronic problem.

Q. Given the history that she provided you and the years that you had treated her for this

condition, did you feel that she had at that point -- she was a patient that had chronic sinusitis?

A. Yes.

Q. Let me ask you questions about the follow-up. Did you perform surgery on her?

A. Yes.

Q. And could you just -- I understand surgeries take -- I don't want you to tell the members of the jury everything in detail, because I'm sure it took some time, but could you give them an overview of what you did for Suzette during the surgery?

A. Well, I just have to review my notes because I did not do all of the surgery.

Q. Okay.

Was part of the surgery performed by Dr. Friedland?

A. Yes.

Q. Okay.

A. I did the sinus surgery.

Q. All right. Why don't you tell us what you did on Suzette Janoff.

A. What I did was I concentrated on the sinus opening and the turbinates, and I removed

part of this turbinate, which was on her left side, to remove that concha bullosa.

And on her right side, I made a window here (indicating) to allow that maxillary sinus to drain.

Q. Was that surgery performed in November of 1993?

A. Let me check my notes.

Yes.

Q. Okay. Was there anything else that you did in that surgery, Doctor?

A. Not that I recall.

Q. Well, did you remove the polyps? Would that have been part of the surgery?

A. Let me go back. Here's my operative note.

What I found -- and I didn't mention this before -- the ethmoid sinuses are honeycomb sinuses in between the eyes.

And as part of the surgery, in order to get to this sinus (indicating), it's necessary to open up this sinus here (indicating), open up a few of those air cells, converting it into one big cavity.

In my operative note, I encountered a

few polyps in the sinuses up here (indicating), and those I did remove and sent them to be checked in pathology.

As far as the thickened lining in this sinus (indicating), I don't do anything about that.

Q. All right. And just, once again, so we're clear, the polyps are a result of the inflammation?

A. Yes.

Q. All right. Did that cure her, Doctor? Did that surgery cure Suzette?

A. No.

Q. Okay. Can you tell us when was the next time after your follow-up that you saw her and what her complaints were?

A. Well, over the next couple months, she was still healing from the surgery.

Q. Do you know if she had returned to flying as a flight attendant for American Airlines?

A. No.

Q. So during that period of time, did you -- did you instruct her not to fly?

A. Yes.

Q. Do you recall how long she was off or out of service as a flight attendant or the approximate amount of time?

A. I gave her a release to go back to work on December 30th.

Q. Of 1993?

A. Of 1993, which would have been a couple of months.

Q. Okay. Was that the end of your relationship with Suzette Janoff, Doctor?

A. No.

Q. Have you been seeing her up to the present time, right now?

A. Yes.

Q. Okay. Let's go back to 1994, and tell me when in 1994 you first saw her.

A. April 13th.

Q. And what was the complaint that she came to see you about?

A. At that point, she had neck complaints and stomach complaints.

Q. Okay.

A. And she did not have any sinus or allergy symptom at that time.

Q. You say allergy symptoms. And as I look

at your record, Doctor, your chart, I notice that you have allergies NKA during most of the visits.

What does that mean, NKA?

A. That's an abbreviation for no known allergies.

Q. All right. Had you, up to 1994, ruled out or made a determination whether she was allergic to anything?

A. No.

Q. Was there -- did you believe or did you suspect that the cause of her sinusitis may have been allergic?

A. At the time, I didn't consider it to be allergic.

Q. Why is that?

A. In part due to the chronic nature that it was not -- in other words, it wasn't seasonal, which we typically see, spring and fall, and because of the appearance of the lining of her nose.

In general, when you see a very red, raw tissue, it suggests more inflammation and, you know, whether it's infection or not, as opposed to an allergy, which will tend to cause congestion, but the lining will look

very pale and not look raw and irritated.

Q. Is that --

A. So that's just a clinical diagnosis.

Q. Let me ask you: Is that something that you have seen in your practice as a physician when you have made a diagnosis of somebody having sinusitis that's related to an allergy versus sinusitis that's related -- or caused by some other source?

VOICE: Form.

THE WITNESS: Yes.

Q. (BY MR. WILLIAMS) Did she -- Doctor, during the times that she came to see you up to 1994, did she continue to give you a history of being exposed to secondhand smoke in the aircraft and getting sick as a result of that?

A. It seemed very consistent that the amount of smoke was significant, that it wasn't just secondhand smoke, that it was. . .

Q. During the times that she came to see you with these complaints, did she give you a history of the amount of smoke that she was exposed to in the airplanes?

A. Yes.

Q. By the way, did you have a chance to fly in the late '80s and smoke in airplanes, Doctor, yourself?

A. Yes.

Q. Let's go to the next visit after that. That's where she complains about either sinusitis or anything relating to her sinus or her ears, Doctor. When is that?

A. June of 1995.

Q. Okay. And can you tell us what -- what was the reason why she came to see you?

A. At that point, she was complaining of congestion in the nose and the right ear after exposure -- after smoke exposure. She was also complaining of tightness in her chest and difficulty breathing.

Q. Okay. When -- your notes reflect that she claimed it was after smoke exposure?

VOICE: Form.

THE WITNESS: Yes.

Q. (BY MR. WILLIAMS) All right. Did you perform an examination of her then?

A. Yes.

Q. And can you tell us what your findings were?

A. At that point, there were some ear findings. I wrote that her eardrum was injected, which means it was red, but it was moving. I did not see a lot of fluid. She had nasal congestion. And -- but that I was able to decongest her nose.

Q. How do you do that?

A. With a nasal decongestant, usually something like Afrin or Neo-Synephrine. And at that time, her lungs were clear. I did not hear any wheezes, which is suggestive of something like asthma or bronchitis.

Q. Okay. What else -- did you do anything else for her besides decongesting her?

A. I put her on the inhaled nasal steroid as well as a steroid inhaler for her lungs.

Q. Now, Doctor, when she comes to see you and she has these complaints, does she get relief immediately or within 24 hours or is this something that's chronic that lasts several days or weeks?

A. I'm not sure.

Q. Okay.

A. Mainly I was treating the symptoms.

Q. Okay.

A. And it seemed to me that they were

chronic with -- they would just have exacerbations periodically, and she would come in for some other treatment.

Q. Okay. How about the next time you saw her after that?

A. December 12th, 1995.

Q. And what history, if any, did she give you when she came to see you in December of 1995?

A. At that time she complained of -- and I'll read from my notes: Smoke exposure during flight, needed O2, which is oxygen, couldn't breathe.

She was complaining of wheezing, complaining of nausea, ear pain, sore throat, and right side symptoms with a blocked right ear.

Q. Okay. When she gives you a description of a blocked right ear, is that something -- what does that mean, that she can't hear from that ear, or is it that feeling that we have when the ear gets almost like packed?

A. It's a eustachian tube problem.

Q. Okay.

A. And back to our diagram, the eustachian

tube goes from the middle ear to the back of the nose. When you look in the ear, you just can see the eardrum. You can't see that.

When I would do an examination and not see fluid and describe the eardrum as moving, it means that if I blow air, the eardrum is like a drum and it vibrates.

All that means is that there is no fluid and there's no -- there's nothing blocking the other end of it. What is harder to diagnose is a eustachian tube dysfunction.

In the drawing, the schematic, it's showing this as a tube. Well, it is a tube, but it's not open all the time. The tube is collapsed, and it's flat.

And what has to happen is the muscles will cause it to open periodically with swallowing, chewing, talking, and that allows a little bit of air to get in there and equalize the pressure.

And there's several reasons why this can be dysfunctioning. One is that the muscles don't work, and the other reason, in children, especially, their eustachian tubes aren't functioning properly.

The other reason is that any inflammation inside the eustachian tube will not allow air to circulate even if it's opening and closing, just like having your nose plugged up when you have a cold.

Q. Are you -- were you able to determine what the cause of the blockage was, whether it was an inflammation or something else?

A. No.

Q. All right.

A. But one of the problems during flying is that if there is a eustachian tube problem and you have a sudden pressure change that the ear can't keep up with, then you will have the symptoms of it being plugged and it's not popping on its own, and that can take several days.

Q. Okay. Did you attach any significance to her complaint that she was exposed to smoke during that flight, again?

A. It seemed that that was causing her symptoms.

Q. Let me ask you this, Doctor, the assumption is throughout this case, you say this is something that's causing her symptoms. How would exposure to secondhand

smoke cause the symptoms?

A. There is several factors that contribute to the irritation in the nose and sinuses and eustachian tube. Basically the lining is the same, and the function of the lining of the nose is humidifying the air and filtering out whatever we breathe in through the nose.

Q. How does it filter out?

A. There are glands in the nose that produce mucous, and there are little cilia, little hairs on the surface of those glands that propel the mucous up and out and clear it, and it goes down your throat.

And it's very specific the way it works and functions. And some of the things that will disturb that -- there's actually a lot of different things that will disturb the proper function.

And some of the toxic chemicals in tobacco smoke will cause paralysis of the cilia, so they're no longer functioning, and the mucous stagnates.

Q. Is tobacco smoke an irritant, Doctor?

A. And it's a direct irritant --

Q. Okay.

A. -- some of the chemicals in the smoke.

Q. All right. Now if you were to assume -- and I want you to assume this as a hypothetical. Despite the fact she's told you about it, that many times she was in a flight where up to 50 people or more than that sometimes were continuously smoking, and she was walking through the cabin and the cabin was full of smoke would that be a condition that would cause this irritation of the sinus passage?

A. Yes.

Q. What, if any, effect is there, Doctor, to repeated chronic sinusitis over many years such as the way she has -- what she has? Does that cause a permanent condition, permanent damage?

VOICE: Form.

THE WITNESS: Yes.

Q. (BY MR. WILLIAMS) Is the opinion you're giving us right now based on a reasonable degree of medical probability?

A. Yes.

Q. All right. Doctor, let's move on and go to the next visit that I see in your chart. Would that be January 12th, 1996?

A. Yes.

Q. So that's roughly a month after the December 12th, 1995 visit?

A. Yes.

Q. And can you tell us, what complaints did she have at that point?

A. At that point, she was complaining of a severe sore throat and a dry cough, a painful cough, and difficulty sleeping at night.

Q. Okay. Was that in any way associated or at least did she claim that was associated with exposure to secondhand smoke, or was that something different?

A. I didn't make any note of any flights at that time.

Q. Okay. How about the next time you saw her?

A. March 10th, 1997.

Q. Okay. Did you at some time learn that Suzette had stopped flying because of her medical condition with American Airlines? Did she bring that to your attention?

A. Yes.

Q. And do you know when that was?

A. I don't remember.

Q. Okay. What did she see you for in March

of 1997?

A. When she came in on that visit, she stated that she was doing well and developed flu-like symptoms while on vacation. She complained of developing an ear problem and sinus infection while flying and that she had been treated with an antibiotic.

Q. Okay. Did you examine her?

A. Yes.

Q. And can you tell us what your findings were?

A. At that time, I noted some congestion, minimal congestion, in the nose, with clear drainage and a slightly injected left ear, which is just inflammation or redness of the eardrum.

Q. I want you to assume, Doctor, that in March of 1997 she was no longer flying in smoke-filled airplanes.

Does your -- does your opinion that her condition, her original condition, was caused by secondhand smoke in the aircraft cabins, does that change?

A. No.

VOICE: Form.

Q. (BY MR. WILLIAMS) Okay. Can you tell us why not?

A. Because subsequent to her retiring from the airlines, it was -- it's my feeling that some of the chronic sinusitis has caused some permanent consequences that are not going to get better, which means, you know, she's more prone to getting infections, you know, more sensitive to irritants, and also because flights that she has taken as a passenger will make her sick in certain circumstances.

Q. What is it about her condition that the damage that has occurred that's permanent that you believe causes her to have these recurrent problems or will cause in the future? If you could tell us maybe the mechanism or the physiology about what has been damaged.

A. Well, some of it has to do with the chronic inflammation, which means that the mucous doesn't drain properly, damage to the cilia and the fact that she had surgery.

That also alters some of the function. She's lost some sense of smell, which has progressed. So these are --

Q. Is the loss of the sense of smell

something that's consistent with somebody having chronic sinusitis?

A. Yes.

Q. All right. Is that something she's going to get back or, if she continues with her chronic symptoms, never regain again?

A. It may or may not come back.

Q. Okay. Are you -- I'm curious. You say she's lost her sense of smell. Is that something she's told you, or do you have any objective test to determine whether or not she has, in fact, lost her sense of smell?

A. That was her complaint. I have not done any formal testing.

Q. All right. Let's go to the next time you saw her then, Doctor, after March of 1997.

A. October of 1998.

Q. Okay. You have a brief note on April 17th of 1997. Do you see that there?

A. Yes.

Q. And what is that? What is she --

A. That she canceled her appointment.

Q. Okay.

A. That she was doing -- that was a

follow-up that wasn't necessary.

Q. Okay. What happened when she saw you on October 28th of 1998? What was the reason for that visit?

A. At that point, she had complained of congestion on the left side of her nose and had been on antibiotics from another operation and had felt better on the antibiotics at that point.

Q. Okay. Did you examine her?

A. Yes.

Q. And what did your examination reveal?

A. Congestion on the left side. I made note that the sinus appeared open where she had had the previous surgery.

Again, I made note of the cobblestoning appearance of her throat, which is due to, you know, postnasal drainage or some irritation.

At that point, I felt that it might be due to allergy, and I felt that she had a sinus infection and put her on an antibiotic.

Q. Why did you feel it might be due to an allergy?

A. Because these were new symptoms on the left side.

Q. Okay. Did you, by any chance, request that she undergo allergy testing some time in 1997 or 1998?

A. I might have, or recommended an allergist.

Q. Okay.

A. I don't remember.

Q. Do your notes or your chart reveal whether she underwent allergy testing?

A. I have the results of skin testing.

Q. Skin testing, what is skin testing, Doctor?

A. With skin testing, this was done by an allergist. What's done is under the top layer of the skin, a small solution that's prepared from different known allergens is injected under the skin,

And typically what they'll do is -- most allergy reaction that we're dealing with in the nose is due to the release of histamine from the cells in response to a stimulus from an allergen.

So the first thing that will be done is the histamine will be injected because that should cause a reaction, swelling, a little redness, itching.

And then the known allergens -- and here we do things like the olive and the tumbleweeds or Russian thistle, and all the common allergens to this part of the country, a dilute solution of that will be injected under the skin and a reaction will be plotted.

Q. Do the results tell you whether she was allergic or had some mild allergies or serious allergies or anything like that?

A. At that time in 1997, the -- there was a normal reaction to the histamine, and then the most -- the largest reaction was to dust mites, and everything else was negative pretty much. There were a few things that were mildly reactive.

Q. Okay. The dust mites, was that -- did she have a significant reaction to dust mites?

A. It was the highest reaction of all of them.

Q. Okay. Are dust mites prevalent in Arizona?

A. They're everywhere.

Q. Okay. By the way, do you know what the percentage of folks walking around have reactions to dust mites is?

A. No.

Q. What did you do after that visit on October 28th, 1998?

A. I treated her with Augmentin, which is an antibiotic, and I gave her the nasal cortisone spray.

Q. Doctor, during the periods of time that she has the condition -- the sinusitis -- the infection, the chronic sinusitis where you place her on antibiotics, is she capable of traveling, let's say, by airplane?

A. Well, there is one thing I want to clarify. If you look at most of my notes, I wasn't treating her with antibiotics.

Q. Okay.

A. And so all her sinus symptoms and the chronic sinusitis that I saw on the x-ray, I was attributing it to an irritant, and that the irritant I was considering was the smoke in the cabin that caused the inflammation in the eustachian tube, the ear pain, the pressure, the congestion. And I was just treating the inflammation. I only prescribed antibiotics once or twice.

Q. Okay. All right. The next time you saw her was April 21st, 2000?

A. Yes.

Q. And can you tell us why she came to see you then?

A. At that point, she was complaining of a headache, an earache, and pressure. She was already on the nasal spray, and she had recently had the flu.

Q. Is the nasal spray, is that something that's recommended for her condition?

A. Yes, the nasal spray is the cortisone spray. We use it typically for allergy, but it works as an anti-inflammatory, so it works for rhinitis or sinus problems that are not due to allergy as opposed to an antihistamine which will only be effective if it's a pure allergy problem.

Q. Doctor, let me ask you something. A little while ago you mentioned the cilia?

A. Yes.

Q. Are those the little hairs that are in the nose?

A. Yes.

Q. When the cilia is damaged because of recurrent irritation or -- is that -- does that come -- does it regenerate itself, or can the cilia be permanently damaged?

A. They can be permanently damaged.

Q. Have you -- besides Suzette Janoff, have you seen that in your practice over the years that you've been doing this?

A. Yes.

Q. All right. Let's go to the next time that you saw her then after that.

A. That was October 3rd.

Q. Okay. I see a notation of 6-1-2000, and maybe I'm wrong, but -- maybe you didn't see her.

A. That was a telephone conversation.

Q. Okay. What happened during that conversation between you and Ms. Janoff?

A. It looks like I had done a CAT scan of the sinuses.

Q. Okay. This would have been the second CAT scan that you had performed --

A. Yes.

Q. -- or that you had asked to be done over the years?

A. Yes.

Q. Do you have the results of that CAT scan?

A. Well -- hold on.

Yes.

Q. And I'm assuming the CAT scan was

performed of the face and the sinus?

A. The sinus, yes.

Q. And can you tell us what the findings were?

A. Yes, according to the report, the -- the surgical opening is open. There are no frontal sinuses, and there is thickening of the lining of the right maxillary sinus.

Q. Okay. You say that the surgery -- the surgical open was opened?

A. They're patent, yes.

Q. Was that the old surgery or was that a new surgery?

A. The original one.

Q. Okay. Now what about the mucosal lining?

A. Was thickened.

Q. Now once again, is that consistent with chronic sinusitis?

A. Yes.

Q. Any other findings?

A. A small concha bullosa of the left middle turbinate, which is probably residual from the original concha bullosa.

Q. What was the reason for ordering the CAT

scan in 2000?

A. Let me see. I'm not sure.

I don't remember.

Q. Was the CAT scan performed by Scottsdale Medical Imaging Enterprises?

A. Yes.

Oh, I see now why. On October 3rd, I made a note of the report, of my own interpretation of the CAT scan.

Q. You had a chance to see it then?

A. Right.

Q. All right. Is that film available to you right now, Doctor? Is that one of the films that is sitting there next to you?

A. I'm not sure.

Q. Do you want to take a look at that and maybe see if that film is there? And if it is, we'll take a break and show it to the members of the jury.

A. No, I don't have it here.

Q. You don't have that one?

A. No.

Q. Okay. We'll just move on then.

Had her condition, Doctor, at least on the CAT scan, had her condition become better,

remained the same, or become progressively worse since the first CAT scan back in 199- -- whatever it --

A. It was about the same.

Q. About the same.

Given her history and what you knew about her, would you anticipate that her condition would have gotten better by then or remained the same or gotten worse?

A. It could have done either thing. You know, some of the environmental triggers may -- you know, it may have gotten better because she didn't have that anymore.

On the other hand, some of the problems were chronic and were not going to go away.

Q. Okay.

All right. When is the next time you saw her after that?

A. October 10th.

Q. And what was the reason for that visit?

A. Well, that was after I had done a little revision surgery.

Q. Okay. Tell us about that.

A. Okay. What was not mentioned in the report, the x-ray report, and the reason why I

read my own x-rays is, inside the nose, there is a small bone right in front of the opening to the cheek sinus.

And part of the surgery, the original operation that I did, to make sure there was adequate drainage of that sinus, it involves removing that bone.

Over the years, the techniques for doing the surgery have improved. Since she was having continued symptoms and recurrent infections, the CAT scan that was done in May, when I looked at the x-ray, it showed that there was still a residual piece of bone right in front of the opening that was not removed on the original operation.

So I recommended going back and doing a little bit more in case that was the cause of her continued problems.

Q. Okay. So she underwent a second surgery by you then?

A. Right.

Q. Do your records show when that surgery was performed?

A. Yes. October 5th of 2000.

Q. Now once again, Doctor, was the

purpose -- and I think you've already told us. Was the purpose of that surgery to attempt to alleviate the condition of chronic sinusitis?

A. Yes, if it was due to a continued blockage.

Q. All right. And can you tell us when was the next time you saw her after that?

A. She was in on October 10th for a postoperative visit.

Q. And what were your findings at that point?

A. Just some of the packing that I put in during surgery.

Q. Was that removed, or was that --

A. That I cleaned out, yeah.

Q. Okay. Was that the last time you saw Suzette?

A. No.

Q. All right. When was the next time you saw her, Doctor?

A. October 23rd of 2000.

Q. It was a follow-up as well?

A. That was still a postoperative visit.

Q. Okay. Doctor, your chart reflects a letter dated December 30, 1993, and I don't mean

to go back, but I want to address this particular letter. Do you see that letter to American Airlines?

A. Yes.

Q. You indicate in that letter that -- and I'll quote the second sentence: She was treated for nasal obstruction and sinusitis. Her prognosis is excellent, and she is fully recovered.

And then you go on to say: She is currently taking no medications. Enclosed you will find a copy of the operative report.

When you say her prognosis is excellent, that seems somewhat to contradict the fact that she was seen by you a few months after that.

A. Right.

Q. Can you tell us what the significance of that letter is, if any?

A. Well, it's a little bit of a dilemma that comes up frequently in work release letters that we're required to write, and basically it means that she healed up from the surgery and there were no restrictions on her work until the next time she gets sick basically.

Q. Okay. Are you telling the airline that she -- okay. I guess that's what I'm trying to

find out. Are you telling the airline that you have not placed her on any restrictions at this time in order to allow her to return her to work?

A. Exactly.

Q. All right. Doctor, let's come back now again to 2000 or 2001, the next time you saw her, and if you could tell us what the reason for her visit was again.

A. May 9th of 2001.

Q. Okay. And why did she see you on May 9th of 2001?

A. At that point, she was on -- had tried several medications. She continued on the nasal steroid spray, the Flonase that I prescribed, and was complaining of headache, sore throat, a burning cough, and had Tylenol Sinus, Claritin, Zyrtec, and several other nasal sprays without relief.

Q. Were you able to provide her any relief when you saw her?

A. At that time, I made note that her nose appeared clear but that it was hyperemic. Again, it was red and raw on the right side, and I had recommended that she try Tylenol Sinus for her symptoms and to start irrigating her nose with

saline solution.

Q. Ms. Janoff has testified that she does that. Can you describe to us what exactly that is and what the purpose of that irrigation is?

A. What I frequently recommend to patients that have chronic sinusitis and what I do routinely after surgery is to have the patients use a salt solution, which is the exact or pretty close to the normal salt of the body fluids and the nasal mucous, and to mechanically, using a little bulb syringe, fill it with the warm saltwater and just flush their nose out, bending over a sink, let it run out, let it go down the back of the throat, and basically mechanically to do what the nose is not doing itself and just flush out the irritants and compensate for some of the dryness.

Q. There's a mechanical -- you seem to suggest, and I think you've done it already, there's a mechanical component to this?

A. Yes.

Q. What is it that the nose is not doing that she has to do, you know, on her own with this type of irrigation?

A. It mainly comes back to the cilia

possibly not propelling the mucous up and out from surgery, from damage to the lining.

There may be more dryness than usual, so it's also restoring a little bit of moisture.

But usually what happens, as the function changes, is the mucous tends to become thicker, not as watery and thin, and it gets hung up inside the nose and blocks the sinus passages.

Q. Doctor, is that what is referred to as a ciliary transport?

A. What the nose does, yes.

Q. Now is ciliary transport or ciliary function essential for mucociliary clearance?

A. Yes.

Q. Is that something she no longer has?

A. It's probably malfunctioning.

Q. Do you have an opinion within a reasonable degree of medical probability as to whether or not that condition that she has will be permanent and remain that way for the rest of her life?

A. I think her problem is permanent.

Q. Okay. Doctor, is your opinion that the chronic sinusitis was related to her exposure to secondhand smoke in aircraft cabins over that

prolonged period of time that she was flying, is that based on a reasonable degree of medical probability?

A. Yes.

Q. We've discussed, and I hate to jump back, but I want to do this at this point, that chronic sinusitis or sinus may be multi-factorial?

A. Yes.

Q. Have you heard that -- have you described that yourself?

A. Yes.

Q. Have you been able, in the case of your patient, Suzette Janoff, to rule out other factors besides secondhand smoke or not?

A. There is no specific test. Most of my treatment, to the best of my ability, with her symptoms, my examination every time she was sick, I attributed it to the high levels of smoke.

And as far as the other factors, her symptoms never seemed to be associated with, at least in the beginning, a typical cold or a virus or, you know, a fever or a bacterial infection.

The other things that can cause sinusitis, like the allergies, there was never that appearance of an allergy. She had no history

of an allergy. The skin testing didn't show a significant allergic component.

As far as the dry air of the plane, that -- she lives in Arizona, so it doesn't get much dryer than that, so as far as the more common causes, she doesn't have little children that have colds all the time.

And it just seemed very consistent that her symptoms occurred on those particular flights where there were a large number of people smoking, where she was trapped in the cabin for many hours, to the point that even if she was on vacation and was in that circumstance, she would get sick.

Q. Okay. Do you, in your practice, Doctor, have you ever treated patients that have been exposed to secondhand smoke in some kind of environment, whether it be the home or some other environment where they have developed any type of illness or irritation?

A. Yes.

Q. All right. Is that something that you treat often?

A. Yes.

Q. Okay. Can you give me an example of what would --

A. The most common example would be the children that have chronic otitis media with effusion where their ears will not clear.

And when you separate out the kids that have allergies, the kids that are in day care, the kids that are sick all the time, a high percentage of the children exposed to secondhand smoke develop otitis media with effusion.

Q. Okay. Where are we on her chart at the present time, Doctor? If you could --

A. May of last year.

Q. Yes. May of last year, what was happening to Suzette Janoff?

A. At that time, I put her on the sinus rinse and then I didn't see her again until March of 2002.

Q. And why did she come to see you in March of 2002?

A. Because she had completely lost her sense of smell.

Q. Okay. And did you have a chance to perform any type of test to determine objectively whether or not this is consistent with her condition, or what did you do?

A. At that point, I usually do not do any

objective test for the sense of smell. It's actually quite difficult, and the -- I gave her another injection of cortisone. Sometimes there can be recovery of the nerves.

The nerves for the sense of smell are high up in the nose, and they're along the septum, along the turbinate, and up -- right about here (indicating), up high in the nose, close to the brain.

And you can actually lose quite a number of those nerve endings and, you know, have very few left that are functioning, and then when they go, then it's as if you suddenly lost your sense of smell.

Q. Is there -- if some of the nerve endings are damaged, will that cause a reduction in the ability to -- for someone to smell appropriately?

A. It affects the ability to smell and taste.

Q. All right. And that's a complaint she had to you on March 4th, 2002?

A. Yes.

Q. Did she come and see you a few weeks later?

A. Yes.

Q. And can you tell us when that was and what her complaints were at that point?

A. On March 21st, after the cortisone shot, she had another CAT scan. And she had a little bit of relief with the cortisone, but it had not totally recovered.

Q. Do you have a -- what about the CAT scan in March of 2002? What did that reveal?

A. Worsening. Sinusitis in the right cheek sinus.

Q. I'm sorry?

A. Worse --

Q. Sinusitis?

A. -- sinusitis on the right side.

Q. I think we do have that film, Doctor.

A. Okay.

Q. If I could ask you to briefly show that to the members of the jury.

A. Sure.

Q. Let's go off the record one second.

VOICE: The time is 3:26 p.m. We're going off the record.

THE CLERK: Is that the end of the film?

VOICE: The time is 3:31 p.m. We're

back on the record.

Q. (BY MR. WILLIAMS) Doctor, I've asked you to retrieve the CAT scans that were taken of Suzette, and now that you have them up there, first of all, would you tell the members of the jury when that CAT scan was taken?

A. This is the original CAT scan from October of 1993, before any surgery was done.

Q. And can you show the members of the jury what your findings were as they relate to the sinus?

A. Okay. Just to orient you, this is an x-ray. I'm looking directly at her face. These would be the eyeballs right here (indicating), or the back of the eye with the muscles.

Now because it's looking face on, this is the right side (indicating), and this (indicating) is the left side.

And what it's showing, mainly, I'd like to point out, these (indicating) are the maxillary or cheek sinuses. This (indicating) is the nose in the middle. These (indicating) are the turbinates that I referred to before.

And as you can see, the middle turbinate on the left side is black in the center. It's

hollow. That's the concha bullosa that I was describing.

On the right sinus, there is a little gray down here (indicating), which is the lining, which is swollen. Normally the sinus lining is not visible on x-ray and all you see is black, which is normal, which is the air, and the thin white outline of the bone.

Q. All right. And you're showing us that bottom part. Is that inflammation?

A. This is a little inflammation (indicating). It's not the best view for that. There is other views that show other varying degrees of inflammation.

Q. The one next to your thumb, Doctor, on the left side, does that show more inflammation?

A. Yes.

Q. Okay. Now would that be -- that and the other clinical picture, would that be a way to diagnose the chronic sinusitis?

A. Yes.

Q. Why don't you show us the latest CAT scans that were taken of Suzette, if you could, Doctor.

If you could tell us, tell the members

of the jury the date and what the findings were.

A. This is the film from March 21st of 2002. And, again, this is a face-on. It's a little bit different level than the other one, but, again, here are the eyeballs (indicating). The nose is in the middle (indicating).

The sinus on her left side is black, and now you can see that there is a more open space here (indicating), and that's the window that was created during the surgery, and that concha bullosa, most of it has been removed.

On her right sinus, there is -- has been progression of the inflammation, and now it is almost filling up the whole sinus. There's very little air left.

Q. Would the air -- the air that's viewed there is the black section, the black part?

A. Yes.

Q. So there's a difference there between the left and the right side?

A. Yes.

Q. Now going back to your original testimony, Doctor, the concha bullosa that you found in -- I believe you trimmed or worked on, that was on the left side of her face, right?

A. Yes.

Q. And is the left side of her face, according to that CAT scan, is that a normal finding?

A. Yes. It has some changes from the surgery, but it has remained open and clear.

Q. Okay. But the right -- is the right sinus in that particular scan, is that irritated?

A. There is inflammation of the lining, and it's now gotten worse.

Q. Okay, Doctor.

All right. You can sit down, Doctor. Thank you.

VOICE: The time is 3:35 p.m. We're going off the record.

The time is 3:38 p.m., and we're back on the record.

Q. (BY MR. WILLIAMS) Doctor, while you were sitting down, I was having a chance to review your chart a little more, and there is a -- there's a note in your chart dated 1-12-96.

It's a handwritten note by you. Do you see it, by any chance?

A. Let me see.

No.

Q. Here. Let me show you a copy --
A. It might not be in order.
Q. -- and see if you recognize that.
(Hands document.)
A. Okay.
Okay.
Q. Do you recognize that? Is that your handwriting? Is that your note?
A. Yes. Yes.
Q. All right. And what was the reason for that note?
VOICE: Objection. Predicate.
THE WITNESS: I don't remember.
Q. (BY MR. WILLIAMS) All right. Would you read it to us?
A. 1-12-96. Suzette Ahrendt is being treated by me and with the prescribed medication is advised not to drive or work. She is expected to recover in seven to ten days.
Q. All right. Do you know what medication you would have placed her on back then that would require her not to drive or work?
A. No.
Q. Okay. Fair enough.
The most -- are we up to the present

date with her treatment, Doctor?

A. Almost, yes.

Q. I guess I should ask you what you did after the last CAT scan when you saw that the right side was inflamed and the left side was not.

And I will ask you.

A. Well, I prescribed some medication. I did a culture. I put her on an oral dose of steroids, a very high tapering dose to treat the inflammation and the loss of sense of smell.

I also put her on an antibiotic for ten days, a mucous thinner.

Q. The steroids to taper off, is that --

A. Yes.

Q. Why do you have to taper off steroids?

A. If you're taking them for more than a week or two, especially a high dose, it suppresses the natural secretion of the steroids by the adrenal glands.

So if you stop suddenly, your body pretty much goes into a little shock because it doesn't have time to recover.

So when we use the high dose, we like to slowly taper it off so the body gets used to -- it starts producing it on its own.

Q. Would that be Prednisone?
A. Yes.
Q. And could -- when exactly did you do that? When was the last time that you treated her and did that, Doctor?
A. That was at the end of March.
Q. Of this year?
A. Yeah, after I obtained that CAT scan.
Q. All right. And have you seen her since March of this year?
A. Yes.
Q. When have you seen her, Doctor?
A. April 22nd.
Q. And why did she come to see you on April 22nd?
A. Because of continued sinus symptoms and drainage and because the -- she had had a total body scan which -- not exactly the same picture that we -- that I did with the CAT scan of the sinuses, but it did show some sinusitis.
Q. In the total body scan?
A. Yes.
Q. The total body scan, that was not done at your request, was it?
A. No.

Q. All right. Did she bring you a report from the scan?

A. No.

Q. Is that something she conveyed to you?

A. Yes. They usually will prepare a CD-ROM disk, and I have no way of downloading that on my computer.

Q. Doctor, can you tell us what Suzette's prognosis is? What does the future hold for her?

A. I think that she will have an altered sense of smell. Whether she gets some recovery, I don't really know. It's possible that occasionally she'll have some sense of smell, but her taste will be altered.

I think she will be very susceptible to infection and will continue to have sinus symptoms.

Q. Okay. When you say infection, are you referring to infection in the sinus area?

A. Yes.

Q. Okay. And the opinion concerning her prognosis, is that something you were giving us within a reasonable degree of medical probability?

A. Yes.

Q. Let me show you, Doctor -- I'll show these gentlemen first -- a bill -- and ladies --

lady.

I had asked your office to print out a bill for me, Doctor, for the services performed by you for Suzette, and let me hand that to you and have you take a look at it.

(Hands document.)

When -- if you look at the two pages, Doctor, when do the services start?

A. October 3rd of 2000.

Q. All right. Your system, I understand, is unable -- or do you know if your system is able to give us bills for the past ten years, or is that the most accurate and recent bills?

A. No, I don't have -- I have the information. It's just not easily obtained because we used a different billing service --

Q. Okay. The chart --

A. -- prior to this date.

Q. Let me ask you this question: The charge that you have there for surgery and office visits --

A. Yes.

Q. -- and whatever you did for Ms. Janoff during that year and a half since those bills were generated, are those charges reasonable and

necessary and customary in this locality?

A. Yes.

Q. For an ENT such as yourself?

A. Yes.

Q. Do you -- you have already told us you anticipate that she's going to have problems in the future.

Do you know how many -- given her history and what has occurred in the past 11 years with your treatment, do you know how often she would need your services in the future in terms of office visits?

A. I've estimated anywhere from two to six office visits a year.

Q. And what is your present charge for an office visit?

A. It depends how complex it is and whether I need to use any -- do any diagnostic testing.

Q. Okay. What about -- let's call it a simple office visit, when she's coming in complaining of the same condition as she has in the past, but you don't have to do much diagnostic testing, what would something like that cost?

A. I think it's $60.

Q. All right. Now if Suzette were to have

another procedure --

A. Yes.

Q. -- another surgical procedure, is that something that, given her history, that you could say she will have within a reasonable degree of medical probability?

A. Based on her past history, she had two operations over ten years, and for certain sinus conditions, it's not unusual for people to have revision surgery in the future.

But, again, it's really hard to project into the future, and, you know, ordinarily I would say, you know, the surgery that could be done has been done, but yet her symptoms and her condition, based on the CAT scan, has gotten worse.

Q. I'm getting the feeling you are unable to tell the members of this jury within a reasonable degree of medical probability that, let's say, in three or four years or in five years she may need to have a revision; is that fair to say?

A. Yes.

Q. All right. But if she did have to have a revision, given her history, could you tell the members of the jury what a surgery like that would

cost?

Let's say at the present time, and we know that things always get more expensive.

A. I know. Based on the type of surgery that she had in the past, the estimate for the -- for future endoscopic sinus surgery is about $4,000 --

Q. That would include --

A. -- for the surgery fee.

Q. The surgery fee, and I guess one-day hospitalization or whatever it is?

A. It's typically outpatient surgery, but there's a fee for the surgery center and a fee for the anesthesiologist in addition to that.

Q. Okay. Now in terms of medicine, Doctor, medications or nasal sprays, will she continue to require those in the future?

A. Yes.

Q. And maybe you don't know the price of that, but can you tell us what you would anticipate she would need in the future in terms of medication?

A. The nasal steroids are approximately $75 to $90 a month. The antibiotics, approximately $100 for a ten-day course of antibiotics.

Q. Now the antibiotic is only something she would require if she developed an infection?

A. Yes.

Q. What about the other medication, the nasal sprays and over-the-counter things, would she require those too?

A. Some of the other medications that I've used, such as the mucous thinners, I'm not really sure how much they are.

Q. Okay.

A. Some of the medication is available over the counter, and some of the nasal injections that are done in the office, the injectable medication, is about $40 a treatment.

Q. Okay. Doctor, you've -- you're obviously charging me for taking time out of your practice in order to give this deposition, are you not?

A. Yes.

Q. And can you tell us what your charge is per hour?

A. 300 and -- I forget -- 25 or 50. I don't remember.

Q. Whatever your charge is, Doctor, 350, that's consistent with --

A. Yes.

Q. -- board certified ENTs in this community?

A. It's probably low.

Q. All right. And you intend to charge -- if you were to give a deposition for the defendants in this case --

A. Yes.

Q. -- the four tobacco companies, you would also charge them the same rate?

A. Yes.

Q. Okay. What I'm trying to say is that's your standard charge no matter who --

A. That's just -- no matter what.

MR. WILLIAMS: Okay, Doctor. I don't have any other questions for you at this time. Thank you.

THE WITNESS: Okay.

MR. WILLIAMS: What we're going to -- it's off.

VOICE: We're off the record.

The time is 3:51 p.m.

(Thereupon, the playing of the videotape deposition of MARIEL STROSCHEIN, M.D., was interrupted and the proceedings continued as

follows:)

THE CLERK: Is that it?

THE COURT: Okay. As I told everyone, we were going to recess between the two tapes. We'll be in recess for 15 minutes. It's 20 minutes after 3. We'll be in recess until 3:35, so just leave your notebooks behind. Gary will pick them up and give them back to you after the recess.

THE BAILIFF: Rise for the jury, please.

(Whereupon, the jury exited the courtroom.)

THE COURT: We'll be in recess until 3:35 p.m.

(A recess was taken at 3:20 p.m.)

(Back on the record at 3:35 p.m.)

THE BAILIFF: All rise, please.

Mr. Hunter is not here.

MR. WILLIAMS: We can start without him.

THE BAILIFF: Okay.

(The bailiff left the courtroom.)

(The bailiff entered the courtroom.)

THE BAILIFF: Rise for the jury, please.

(Whereupon, the jury entered the

courtroom.)

THE COURT: Thank you. You may be seated.

For the record, the jury is now back in court.

Do you find it's better with the light off or on? It doesn't affect your ability to take notes? I think it's easier to see if the light is off.

And what time tomorrow, everybody?

THE JURY PANEL: 9:30.

THE JURY PANEL: 9:45.

THE COURT: Has he brought you doughnuts yet? No?

Okay. You may proceed.

(Thereupon, the continuation of the videotape deposition of MARIEL STROSCHEIN, M.D., was played to the jury as follows:)

CROSS-EXAMINATION

BY MR. REILLY:

Q. This is a continuation of the video deposition that was taken by Mr. Williams some time ago.

A. Yes.

Q. Okay. So I'm not going to ask you your name and that sort of thing --

A. Okay.

Q. -- because the jury already will have seen you for however long that video is, okay?

A. Uh-huh.

Q. Doctor, you are here today because you are one of the treating doctors of Ms. Janoff, the plaintiff in this case, correct?

A. Yes.

Q. Okay. Before we get into the bulk of this cross-examination, let me ask you a few things about perhaps what you did in preparation for today.

A. Okay.

Q. Can you tell me if you've done anything to get ready to give this part of your examination today?

A. I reviewed my deposition, my original deposition, the discovery deposition, and the deposition of Dr. Kronberg.

Q. Okay. And when did you do all that?

A. Yesterday.

Q. It must have taken a little while.

A. Yes.

Q. How long did that take?
A. I spent about three hours.
Q. Have you read the deposition of Dr. Casiano?
A. No.
Q. Have you been advised as to any of the content or any of the testimony of Dr. Casiano's deposition?
A. Only what Dr. Kronberg alluded to in his deposition.
Q. Dr. Casiano got deposed after Dr. Kronberg.
A. Okay.
Q. Dr. Casiano was just deposed in the last ten days.
A. Okay. Well, the only mention that Dr. Kronberg made of Dr. Casiano, I'm -- I assumed it was his deposition, or it may have been his examination of the patient.
Q. Okay. Do you know that Dr. Casiano has actually been deposed in this case now?
A. Yes.
Q. Okay. And you've been advised of that by Mr. Williams?
A. No, it was just what I read in the

deposition of Dr. Kronberg.

Q. Okay. Well, Dr. Kronberg got deposed before Dr. Casiano, so he wouldn't know, just to --

A. Okay.

Q. He wouldn't know that Dr. Casiano was being deposed.

A. Okay. Then that was my assumption, the fact that he was called in as a -- to give expert testimony or to examine the patient.

Q. Okay. And in terms of what Dr. Casiano has actually testified to, you haven't seen that yet?

A. No.

Q. Okay. And I presume that Mr. Williams gave you the deposition of Dr. Kronberg?

A. Yes.

Q. And that his -- you understood that his partner took that deposition?

A. Yes.

Q. Okay. Did you have anything to do with the preparation of plaintiff's counsel in taking the deposition of Dr. Kronberg?

A. No.

Q. No? Didn't consult with him in any

way --

A. No.

Q. -- in connection with that?

A. Huh-uh.

Q. And other than reading these three -- reviewing your two prior --

A. Yes.

Q. -- depositions and reading Dr. Kronberg, have you done anything else in preparation for today?

A. Not in addition to what I prepared for with the discovery deposition.

Q. Okay. With the discovery deposition, as I recall, you read the deposition of Dr. Persky, a physician whose deposition was taken in an entirely different case?

A. Yes.

Q. And you also looked at some textbooks and other literature to refresh your recollection regarding issues relating to chronic sinusitis or sinusitis?

A. Yes.

Q. Okay. So on to the time that you have indicated previously that you've spent, and I think that's a total of about six hours, we should

now add about three hours for the preparation time yesterday?

A. Yes.

Q. Okay. And I assume you are billing for that time at your standard rate of $350 an hour?

A. Yes.

Q. Okay. So up to today, I think you have -- how much time do you have in this case already? You've got --

A. Well, the time I prepared, plus the depositions that I've already given.

Q. Okay. And do you remember how much you charged for the depositions themselves?

A. No.

Q. Okay. You've charged for the six hours of preparation, for the prior depo, three hours for getting ready for today. I presume you're --

A. Yes.

Q. -- going to charge somebody for that?

A. Yes.

Q. And then I don't remember how long your deposition taken by Mr. Williams took. About an hour?

A. I don't recall.

Q. Two hours? Somewhere in that range?

A. Somewhere.

Q. Okay. This isn't a contest to see if you can remember.

A. I don't do the billing, so I don't really pay attention.

Q. I understand.

And the discovery deposition taken by Mr. Kodsi and others took about four hours?

A. Yes.

Q. So that would be a total of roughly six hours of deposition time and nine hours of preparation time?

A. Yes.

Q. Okay. We can do the math and figure out how much this all comes out to.

A. Okay.

Q. All right. Can you tell us when the last time you saw Ms. Janoff was?

A. As a patient?

Q. Well, if you've seen her for some other reason more recently than as a patient, I need to know that. I'd appreciate knowing that.

A. Well, that would --

Q. She's here today, right?

A. Right.

Q. Okay. But not including the fact that she's here today, when is the last time you saw her?

A. Except for seeing her in the store, you know, just --

Q. Well, you know, the last time I think you indicated --

A. And that's --

Q. -- you saw her in a knitting store?

A. Exactly.

Q. Okay. Other than seeing her in the knitting store?

A. Other than that, I -- the last time I saw her was in the office on April 22nd of this year.

Q. All right. And did you recently get some laboratory results back from that examination?

A. Let's see. I don't know if my chart is in order. The last culture I did was on May 8th.

Q. If -- well, explain that to me, would you? How -- if the last time you saw her was April 22nd, how a culture was taken on May 8th. Would she have come in --

A. No, I'm sorry, that's when I got the

report. I don't know.

Q. Did you do some sort of swab on April 22nd?

A. Wait. My notes might not be in order. I have an office visit from June 27th.

Q. And is the lab report from June -- is it the June 27th visit?

A. From 5-7 was the report date, so I don't know when it was done. It probably was done on the April visit and it usually takes about a week to get a final report.

Q. All right. And do you have that report in your file?

A. Yes.

Q. And what does it reflect?

A. Nasopharyngeal swab, two results, one, some normal respiratory flora, and a light growth of Acremonium species.

Q. What is Acremonium species?

A. I have no idea.

Q. Is it a fungus?

A. I don't know.

Q. All right. And do you know where the swab was taken from, what part of her body?

A. Nasopharynx --

Q. Okay. So --
A. -- or nose.
Q. -- nose?
A. Yeah.
Q. And you would have been the person who took it or would a nurse take that?
A. No, usually I do that myself.
Q. All right. And the reason for doing it was to do what?
A. Let's see. That -- normally it's to decide which antibiotic to prescribe in someone with chronic sinusitis.
Q. All right. And does the lab inform you whether or not the substance that they have cultured is either a bacteria or a fungus or something else?
A. No.
Q. They just identify it?
A. Yes.
Q. And then it's up to you to figure out what it is?
A. Right.
Q. Okay. What kind of animal it is, right?
A. Right.
Q. And is there any particular reason

why -- well, strike that.

Was anything done as a result of getting the lab results back?

A. I prescribed a Prednisone taper.

Let me see.

And Levaquin.

Q. A Prednisone taper is a steroid?

A. Yes.

Q. And did you do that as a result of -- the results of the laboratory, or was that done on April 22nd?

A. That was just done along with the antibiotic in April, and when I got the culture back, I didn't change anything.

Q. Okay. By the time the culture came back, was the antibiotic and the Prednisone all taken? In other words, had the prescription run out?

A. I don't recall.

Q. Okay. In any event, no more treatment was done as a result of the lab results?

A. Correct.

Q. Okay. And then you said you saw her again on June 27th --

A. Yes.

Q. -- of this year?
A. Yes.
Q. And I don't think we've seen that note yet.
Can you tell me, is that -- maybe you could just show me that note real quick, if you don't mind.
A. Sure.
(Hands document.)
Q. Thank you.
Okay. Thanks.
(Hands document.)
A. Thank you.
Q. I think we'll talk about that in the course of the entire examination, if you don't mind.
All right. Doctor, let's cover a few things about your background and your training.
You are an otorlaryngologist, right?
A. Yes.
Q. And your practice is here in Scottsdale, Arizona?
A. Yes.
Q. You've already gone over your educational background with Mr. Williams, so I

won't repeat that.

Let me just sort of summarize it by saying that for the last, over a decade, you've been a clinical physician, correct?

A. Yes.

Q. You've been -- you've had your practice here in Scottsdale and you've been taking care of patients, right?

A. Yes.

Q. Your career has not been one in which you engaged in research?

A. No.

Q. Okay. During the course of either your medical education or at any time during your professional career, have you ever been involved in a research project designed to identify the cause of a disease?

A. No.

Q. Okay. There are methodologies that medical scientists employ in order to attempt to establish the cause of a disease, correct?

A. Yes.

Q. They try to determine whether or not something that they are suspecting may be a cause is, in fact, a cause, right?

A. Yes.

Q. Among the methodologies that they can choose from to attempt to make such a proof would be some sort of in-lab testing?

A. Yes.

Q. They could try some sort of animal testing?

A. Yes.

Q. They could try epidemiology testing --

A. Yes.

Q. -- where you look at groups of exposed people and groups of unexposed people and see whether or not the exposed people have a greater incidence of a particular disease than the unexposed people, right?

A. Right.

Q. And they could attempt to control for other possible causes of the disease so that the exposed group doesn't have other explanations for why they might develop that illness, right?

A. Yes.

Q. Okay. Are there any other methodologies that you know of that medical science or medical scientists could employ in order to prove or disprove that there is a causal relationship

between a disease and the suspected entity? In other words, have I missed something?

A. One commonly used technique, especially with drug research, is the prospective randomized double-blind, controlled study as a provocative test.

Q. Okay. In other words, a human study?

A. Yes.

Q. Have you ever been involved in any one of those four kinds of studies in terms of trying to identify the cause or whether a particular substance or thing is a cause of a disease?

A. In residency, some of the clinical research employed some features of a, you know, retrospective epidemiologic type study.

Q. Okay. And was there a disease and a suspected causative agent that were involved in your study during your residency?

A. There were quite a few, and right offhand, I can't think of the specifics. There were a lot of things that we were looking at with regards to infectious diseases and cancer. And I wasn't involved in the publication, so I don't remember a lot of those studies.

Q. Okay. You weren't directly related as a

researcher?

A. No, we were just gathering data.

Q. Okay. You indicated during your earlier examination that you did a literature review in connection with getting ready for your last deposition?

A. Yes.

Q. And in your review, did you find any literature that addressed studies of any of those three types, employing any of those methodologies, looking at whether environmental tobacco smoke caused sinusitis?

A. Most of the studies that I reviewed, there was actually a lot of conflicting results. Most of them dealt with rhinitis, and I can't recall any related to sinusitis.

Q. Okay. You looked at a number of textbooks and other writings, but none of them indicated that environmental tobacco smoke was a cause of sinusitis, correct?

A. Correct.

Q. Was there -- there was no restriction except a self-imposed one of time on the scope of your literature review on that subject, was there? In other words, you were free to look wherever you

wanted to?

A. That's true, but I -- when I did my review, I was not looking for articles on environmental tobacco smoke and sinusitis.

Q. You just happened to -- I realize you weren't specifically necessarily looking for exactly that --

A. Yes.

Q. -- but in the course of your review, you looked in textbooks that addressed the causes, for example, of sinusitis, right?

A. Yes.

Q. And environmental tobacco smoke wasn't listed among them, was it?

A. I don't recall.

Q. Okay. Doctor, I mentioned a minute ago that you have been a clinical practitioner, right?

A. Yes.

Q. And can you remind me how long you've been taking care of patients in your clinical practice?

A. I finished my residency in 1989, and that's when I moved here and started private practice.

Q. Okay. And you joined a group in 1989,

right?

A. Yes.

Q. And you've been with that group ever since, or are you --

A. No, I was employed by another physician for two years.

Q. All right. And over the time your practice has grown?

A. Yes.

Q. In current years, you see thousands of patients a year?

A. Yes.

Q. And in recent times, between one and 2,000 of those patients every year will suffer from sinusitis, either acute or chronic?

A. Well, maybe. I don't know if it's that high.

Q. Okay.

A. I would say that's how many visits I see. May be the same patients.

Q. Okay. What is --

A. I haven't quantified.

Q. Okay. So that may be the number of patients you see -- I'm sorry, patient visits you have every year for patients suffering from acute

or chronic sinusitis?

A. Yes.

Q. But that doesn't necessarily mean that that's exactly the number of patients because one patient may come back more than once a year?

A. Exactly.

Q. Okay. But this is a very common illness here in Arizona?

A. Yes.

Q. A very common illness here in Scottsdale?

A. Yes.

Q. A very common illness in the United States?

A. Yes.

Q. Okay. As a matter of fact, it is the most common chronic illness in the United States today, isn't it?

A. Yes.

Q. And it's -- the number of people who are being diagnosed with sinusitis is on the rise, isn't it?

A. Yes.

Q. But nobody knows why, do they?

A. There are several theories.

Q. That's the point, they're just theories

though, aren't they?

A. Yes.

Q. About 25 percent of sinusitis people are people who suffer from allergies?

A. Maybe.

Q. If you've given that number in your prior testimony --

A. Yes.

Q. -- you wouldn't quibble with it, I take it?

A. No.

Q. I realize you didn't sit with a calculator --

A. No.

Q. -- and your patient sheets and figure out an exact number, but that sounds pretty close?

A. That was just based on the prevalence of allergy in the population.

Q. Okay. Based on your own personal experience and the literature review that you did, the identified causes of sinusitis are allergies, bacteria, viruses, molds, fungus, anatomic abnormalities, in other words --

A. Yes.

Q. -- your physical makeup, dry air, smog,

and other environmental causes?

A. Yes.

Q. Okay. They all exist right here in Scottsdale, don't they?

A. Yes.

Q. As a matter of fact, some of them exist here in significant numbers?

A. Uh-huh.

Q. Like dry air is a big cause of sinusitis here in Arizona, isn't it?

A. Rhinitis, I would say.

Q. Okay. And that's because the very dry air here tends to dry out the nasal passages, right?

A. Yes.

Q. And that has an effect on the ability of the mucociliary clearance mechanism of your body, right?

A. Yes.

Q. And that's how your sinuses function; that's how your nasal passages function?

A. Yes.

Q. Okay. In part?

A. Uh-huh.

Q. The exact functioning of the cilia of

the little hair-like structures on the cells that line your nasal passages and line your sinuses is still being investigated today, isn't it?

A. Yes.

Q. As a matter of fact, current medical literature looks -- includes articles by researchers who are trying to begin to understand how and why and when the cilia work, correct?

A. Yes.

Q. You've not played a role in that scientific research though, have you?

A. No.

Q. It can be very difficult in your patient population to sort out what is causing someone's sinusitis, correct?

A. Yes.

Q. You try though because you are a clinician, and that's what part of your job, you think, is, right?

A. Yes.

Q. But it's a very inexact science, isn't it?

A. Yes.

Q. Sometimes you have nothing but the history of the patient to go on?

A. Correct.

Q. A lot of times there is no testing you can do; there is no -- there is no real scientific methodology that you can bring to bear to try to identify what somebody's cause of their sinusitis is?

A. There are things that can be done, but we don't do it clinically.

Q. Well, sometimes there are things that can be done clinically that you do do, right?

A. Yes.

Q. For example, you can order allergy testing?

A. Yes.

Q. You can order bacteria testing?

A. Yes.

Q. You can do like you did -- like we were talking a minute ago, you can take a swab and you can send it off to a lab and see if it cultures out a bacteria?

A. Yes.

Q. You don't oftentimes do that though, do you? Bacterial swabs are not the norm, are they?

A. Things have changed, and actually it is more common today.

Q. Is that right?

A. Yes.

Q. Do you get the -- I always thought that the reason why nobody bothered to do swabs was because the bacteria was usually gone before the results from the lab came back.

A. Well, we've possibly overtreated people over the years and now we have a problem with resistant bacteria, so now it is becoming more important, although the -- and there is controversy over whether the testing is accurate, and so we do the best we can.

Q. Okay. For anatomical situations, sometimes you can take radiographic examinations, you can take x-rays or CT scans, and see if you can identify anatomic explanations for why someone may be suffering from sinusitis?

A. Yes.

Q. Okay. So on occasion, you can employ -- can you -- can you culture for a virus?

A. We don't.

Q. Could it be done?

A. Yes.

Q. But not done ordinarily?

A. No.

Q. As a lawyer, I don't know why you don't do that ordinarily. Could you tell me that?

A. Well, there's probably over 150 to 200 rhinoviruses that would cause the common cold, and there would be no practical benefit in knowing which virus it was, or if it was a virus, because currently there is no treatment for that.

Q. Okay. So even if you knew, you couldn't do anything about it?

A. Correct.

Q. And ordinarily the body's defense mechanisms attack and successfully defeat those viruses anyway?

A. Yes.

Q. Okay. So we're still relying on our bodies to do most of the work for some of these causes of sinusitis?

A. (Nods head up and down.)

Q. Okay. Oftentimes you, as a physician, can't identify any one cause; there may be many causes for a person's sinusitis?

A. Yes.

Q. And then it's really difficult to tell which role any one of those potential factors is playing in the development of somebody's sinusitis?

A. Sometimes, yes.

Q. As a matter of fact, all the time; you almost never can tell exactly what is causing someone's sinusitis, can you?

A. Well, no. Sometimes you can tell, if somebody has a bacterial infection and you identify it and it -- you treat it and it goes away.

Q. Other than a bacterial agent or a fungal agent, you could culture for a fungus, and if the patient -- if the lab work comes back that the patient has a fungus, then -- and if you treated the patient with antifungal medication and the sinusitis went away or got better, then you might be able to say: Well, I really do think that it was the fungus?

A. You could.

Q. Okay. Same applies to a bacteria. If you cultured for a bacteria, you found a bacteria, you grew a bacteria in a Petri dish in the laboratory and then you prescribed an antibiotic that was known to be effective against that bacteria, you administered it to the patient and the patient got better, you could say: You know what, I really think it was the bacteria that

caused that patient's problem?

A. Yes.

Q. Okay. Other than that though, you're pretty limited?

A. No, I think there's many instances where you absolutely know what is going on.

Q. Really?

A. Yes.

Q. What would be other instances where you'd absolutely know what was going on?

A. Well, not too long ago, a patient presented with a very severe chronic sinusitis, long history, severe pain, and he was found to have a piece of wood lodged in his nose from an accident that happened 70 years before.

Q. That will do it.

A. And when I removed the foreign body, he got better.

Q. Okay. Thank you.

Your patients run the gamut --

A. Yes.

Q. -- of why they -- or why you suspect they developed their sinusitis?

A. Yes.

Q. Okay. In your patient population, you

have some flight attendants, some current flight attendants?

A. Yes.

Q. Not too many though. Out of hundreds of patients that you see every year, not too many of them are flight attendants, right?

A. Correct.

Q. I think previously you've indicated you've had about 24 flight attendants?

A. About that.

Q. Okay. Flight attendants still get sinusitis today, don't they?

A. Yes.

Q. Flight attendants that have never been exposed to cigarette smoke on board an aircraft?

A. Yes.

Q. And they get their sinusitis for all the reasons that everybody else here in Scottsdale gets sinusitis?

A. Yes.

Q. And the causes of their sinusitis are just as difficult to identify as everybody else here in Phoenix -- Scottsdale, Arizona, right?

A. Yes.

Q. You think that today's airplane cabin

environment lends itself to the development of chronic sinusitis, acute and chronic sinusitis, right?

A. In some people. I think the -- considering the air quality, the dryness, the pressurization, it could be a contributing factor.

Q. In addition to that, flight attendants, as they always have, encounter hundreds of people every day?

A. Yes.

Q. Those people have their own viruses, their own bacteria, their own molds and fungus that they bring with them, right?

A. Yes.

Q. And on board airplanes, when all those people get on and all those people get off, and a whole new set get on and a whole new set get off, flight attendants are exposed to that, aren't they?

A. Yes.

Q. And flight attendants do more than just stand in close proximity to these people, don't they? They actually have to touch the people and the things the people touch, don't they?

A. I think lately, no, they don't do that

much anymore. Since they did away with meal service, no, you don't see them as often.

Q. The flight attendants don't spend as much time today handing out food and trays and drinks and things like that as they did ten years ago, right?

A. Yes.

Q. And that's because the airlines have simply cut back on the food services that they provide passengers today?

A. Yes.

Q. Okay. But they still hang their coats up and they still assist them to their seats and they help them with their luggage, right?

A. No.

Q. You don't think they do that either?

A. No. I'm sorry.

Q. Okay.

A. Someone traveling with three small children and five carry-on bags would love help getting on the plane.

Q. Remind me not to take your airline, whichever one it is.

A. Okay.

Q. And that recirculated air puts in motion

the bacteria and the viruses that people bring on board?

A. That's the presumption, yes.

Q. Okay. Well, the -- and even if you didn't have the air recirculating, if someone were to sneeze in your area or cough in your area, that puts into the atmosphere all those bacteria and viruses, doesn't it?

A. Yes.

Q. Okay. For example, if I were to walk outside your office here in Scottsdale, Arizona, where we're taking this deposition, I'll immediately encounter dust, right?

A. Yes.

Q. I'm probably encountering dust right here in your office, no offense?

A. Yes.

Q. And included in the dust are dust mites, right?

A. Yes.

Q. They are everywhere. They are -- I learned the word ubiquitous many years ago and it never left me. Dust mites and dust are ubiquitous, they're everywhere?

A. Yes.

Q. Okay. Let's talk about your care of Ms. Janoff in this case. You first saw her in January of 1992, right?

A. Uh-huh.

Q. And please at any time you need to refer to your chart, don't hesitate to do it.

A. Okay.

Q. Okay. She had been -- strike that.

You were in a group at that time, right?

A. With one other physician.

Q. A small, very small group?

A. Yes.

Q. Just you and another doctor.

There had been another doctor, a Dr. Weiss, in that group before you?

A. Yes.

Q. You took his place?

A. Yes.

Q. And Dr. Weiss had actually seen Ms. Janoff on two occasions before you saw her?

A. Yes.

Q. Okay. You would have had those records in her chart?

A. I have them in the chart now.

Q. And you would have had them the first

time you saw her in January of 1992?

A. Yes.

Q. Okay. You wouldn't have had anybody else's records?

A. No.

Q. Do you know whether or not she was seeing any other physicians for the same conditions that she was going to see Dr. Weiss for in 1989 and 1990?

A. I don't know of anybody else.

Q. Okay. And whether or not those physicians were making recommendations and treatment programs and that sort of thing for Ms. Janoff, you have no knowledge of that?

A. Right.

Q. And whether she was adhering to those treatment programs and following the doctor's advice during that time frame, from anybody else other than Dr. Weiss, you have no knowledge of that?

A. Correct.

Q. When you saw her for the first time, would you have looked back at the earlier entries in the chart to see what she had been to see Dr. Weiss for?

A. I might have if it was available at that time, but I don't remember.

Q. Dr. Weiss saw her on two occasions, in 1989 and 1990, right?

A. Yes.

Q. Okay. And in your treatment of Ms. Janoff and as you sit here today -- well, strike that.

Let's take these two visits one at a time.

What did Dr. Weiss see her for in 1989? Do you either remember or can you tell from reviewing the chart?

A. From the note from 1989, it looks like there was a history of sinusitis, and his diagnosis at that time was eustachian tube dysfunction.

Q. All right. So he didn't diagnose sinusitis; he diagnosed a eustachian tube dysfunction, right?

A. Yes.

Q. Did he identify what was the cause of eustachian tube dysfunction?

A. No.

Q. But he treated it, right?

A. Yes.
Q. And how did he treat it?
A. I can't completely read his notes, but it looks like he prescribed Seldane.
Q. An antihistamine?
A. Yes.
Q. All right. The -- was Ms. Janoff already on a medication? Can you tell that from the record?
A. It looks like Augmentin.
Q. She was on an antibiotic?
A. Yes.
Q. So somebody else had thought that whatever was going on with her was bacterial in nature, right?
A. Yes.
Q. From your review, does it look like an acute problem?
A. I can't tell --
Q. All right.
A. -- from the notes.
Q. Can we go to the next visit?
Oh, by the way, did you assume that either today or back when you were treating Ms. Janoff in 1992, did you assume that she had

been exposed to cigarette smoke on board airplanes any time in close proximity to that visit, the '89 visit?

A. I didn't -- I don't know. There was no mention in this doctor's notes, and I did not -- I didn't go over that.

Q. Okay. Let's go to the next visit. I think it's November 13th, 1990.

A. Yes.

Q. Can you tell from the note what Dr. Weiss diagnosed Ms. Janoff with at that time?

A. I can't read it at all.

Q. Can you tell what he did for her?

A. No. This might say Seldane, but I don't know.

Q. Okay. Can't read his handwriting?

A. I can't read it at all.

Q. And at the time you gave care and treatment to Ms. Janoff up through present day --

A. Yes.

Q. -- did you assume at any time in close proximity, weeks of that visit, that she'd been exposed to secondhand smoke on board airplanes?

A. Yes.

Q. Your assumption was that she had been?

A. That she had, yes.

Q. Do you know whether -- do you know today whether or not Ms. Janoff, on that November 13th, 1990, visit, had been exposed to secondhand smoke on board airplanes for weeks?

A. I don't know from that visit.

Q. Okay. Let's go to -- well, strike that.

During the time that you cared for Ms. Janoff, she was a flight attendant, right?

A. Yes.

Q. And was it your understanding that she was an international flight attendant, flying internationally?

A. I know that now, but I --

Q. Didn't know it at the time?

A. I don't know if I was aware of it at the time.

Q. Did you know then or do you know now that earlier in her career she had been a domestic flight attendant?

A. I knew that.

Q. You knew that. When did you know that?

A. I don't know when I knew it, but, yes, I am aware that she had done both domestic and international.

Q. All right. And at some point in time, did you find out when she switched from being a domestic flight attendant to being an international flight attendant?

A. No.

Q. Do you know whether she ever switched back from being an international flight attendant to being a domestic flight attendant?

A. No.

Q. Or if she ever switched back again from being a domestic flight attendant for a second time and being an international flight attendant a second time?

A. No.

Q. When you were treating her starting in January of 1992, did you have some knowledge then as to whether or not smoking was permitted on domestic flights?

A. I don't remember when that changed.

Q. All right.

All right. The first time you met with Ms. Janoff, she made mention of smoke on the airplanes, didn't she?

A. Yes.

Q. And you wrote that in your chart?

A. Yes.

Q. Okay. Do you recall having any conversation with her at that point about whether it was necessary for her to be exposed to smoke on airplanes?

A. Vaguely. I'm sure we discussed it.

Q. Do you remember what your conversation was?

A. No.

Q. Okay. At that visit in January of 1992, did you make any recommendation to Ms. Janoff that she try to avoid being exposed to secondhand smoke?

A. No, I don't recall that. At the time, I assumed it was not an option.

Q. And why did you make that assumption?

A. Because it's a problem that I confront every day with patients who have many environmental exposures for various reasons and problems with children in day care.

And for most people, to tell them that they have to, you know, give up their livelihood or quit their job and keep their children home is not an option.

Q. All right. And was your assumption back in 1992 that that's what Ms. Janoff would have had

to have done, give up her job?

A. Yes.

Q. And that's why you didn't recommend to her that she not try to avoid being exposed to secondhand smoke on board aircraft?

A. Probably.

Q. If you had known that she didn't have to give up her job, that she could have remained a flight attendant, that she could have flown for years and years and years without ever again being exposed to secondhand smoke, would you have advised her to do that?

A. Possibly, yes.

Q. Sure you would have, right? If that's what she said was bothering her, wouldn't you have said to her: Well, gosh, if it's bothering you, I think you ought to avoid it?

A. Yes.

Q. Okay. It makes sense, right?

A. Uh-huh.

Q. And if she could have maintained her job as a flight attendant and avoided cigarette smoke and if it bothered her, you would have expected her to do that, right?

A. Yes.

Q. As a matter of fact, you make recommendations to your patients all the time as to changes they need to make in order to avoid being put in positions where they're exposed to things that the patients think are bothering them, right?

A. Yes.

Q. And if a patient tells you: I think my cat is causing me a problem, you tell them: Better lose the cat, right?

A. Yes.

Q. If they tell you that: I think my -- I think my gardening is causing me a problem, being close to pesticides or being in the dust and dirt, you tell them: You better stop, right?

A. I try.

Q. And sometimes they do it and sometimes they don't, right?

A. Right.

Q. That goes for allergy testing too, doesn't it? Doctors recommend that patients have allergy testing. Sometimes they do it and sometimes they don't, correct?

A. Right.

Q. It's their choice?

A. Uh-huh.

Q. Doctor, when you saw her in January of 1992, what did you diagnose her with?

A. Rhinitis.

Q. You didn't determine a cause of her rhinitis though, did you?

A. Yes, I assumed it was due to the smoke exposure.

Q. Is that right?

A. Yes.

Q. Okay. And you made that assumption because she told you she was exposed to secondhand smoke on board airplanes and that it bothered her, right?

A. And because I found evidence of rhinitis.

Q. Sure. You found the disease, right?

A. Yes.

Q. You found an inflammation in the lining of her nose?

A. Right.

Q. But the inflammation in the lining of her nose doesn't really tell you what caused it, does it?

A. No.

Q. And so now you're going to rely on the

history the patient tells you in order to try to make a connection between something in the history and what's going on in the nose?

A. Yes.

Q. Okay. So you do the best you can, right?

A. Yes.

Q. This is not an exact science, correct?

A. It's not always.

Q. Sure. I understand the wood splinter in the nose analogy or example, but. . .

So you told her to do what?

A. Use the topical steroid nasal spray.

Q. All right. And what was that going to do for her?

A. Reduce the inflammation.

Q. Okay. And did you tell her to take any steps of any kind to reduce exposure?

A. Not that I recall.

Q. Okay. Can dry air have been playing a role in her rhinitis?

A. It could.

Q. Okay. Did you make any recommendations to her on that visit about possibly doing something about her dry air?

A. No.
Q. Nothing you can do about it outdoors here in Arizona?
A. No.
Q. It's very dry on airplanes, right?
A. Yes.
Q. And the air that they draw in up at altitude is very dry, isn't it?
A. Yes.
Q. Dryer than even here, isn't it?
A. Probably.
Q. Did you make a recommendation to Ms. Janoff that she try to do anything on board the airplane to deal with dry air?
A. Over the years, I have. I didn't make a note of it in that.
Q. Okay. What things have you told her that you think she should try on board airplanes when she's flying to deal with the extraordinarily dry air on board airplanes?
A. There's a lot of saline nasal sprays that are available over the counter, moisturizing agents.
Q. Okay. And the idea is to hydrate or moisturize the lining of your nose, right?

A. Yes.
Q. Did you make any recommendation to her that she fill cups with water on the aircraft in an effort to put air -- put moisture in the air?
A. I don't remember.
Q. Okay. So if she did that on board airplanes, that's not of your suggestion?
A. No, I don't think I've ever recommended that.
Q. Did she ever tell you she was doing that?
A. I don't remember.
Q. Okay.
The second time you saw her, you thought she had a bacterial infection, right?
A. Yes.
Q. She had all the signs of it, didn't she?
A. Yes.
Q. She had green discharge?
A. Yes.
Q. She had red, raw nasal lining?
A. Yes.
Q. Classic signs of somebody with a bacterial infection?
A. Yes.
Q. And you said today we would swab

somebody and send their swab to a lab. You didn't do it then?

A. No.

Q. Okay. Because it wasn't a practice then, right?

A. Right.

Q. And so today we don't know what the bacterial agent was, but, as you sit here today, you feel reasonably confident that that was a bacterial infection?

A. Yes.

Q. You prescribed an antibiotic?

A. Yes.

Q. A fairly broad spectrum antibiotic, amoxicillin?

A. Yes.

Q. And do you know for how long she'd had her symptoms before she came to see you?

A. No.

Q. Do you know how long she'd had her symptoms after she left you?

A. No.

Q. Okay. So -- and, of course, no one can tell where you exactly got your bacterial agent, right?

A. Correct.
Q. She might have gotten it on airplane; she might have gotten it at home?
A. Correct.
Q. She might have gotten it at the knitting store?
A. Uh-huh.
Q. You can't tell?
A. Correct.
Q. Bacteria, like dust mites and viruses is ubiquitous, it's everywhere?
A. Yes.
Q. This was an acute sinusitis?
A. Yes.
Q. Caused by the bacteria?
A. Yes.
Q. The next time you saw her was a year and two months later, July of '93?
A. Yes.
Q. Okay. It's not unusual for anybody to have a bacterial infection once a year in their nose, right?
A. No, not unusual.
Q. Ms. Janoff had been seen by Dr. Weiss for an ear problem in 1989. Not unusual for a

flight attendant to have an ear problem, right?

A. Correct.

Q. When planes rise and descend, the pressure in the cabin creates a wonderful atmosphere for ear problems to develop, right?

A. Yes.

Q. She didn't have any ear problems in 1990 that you see in your chart?

A. No.

Q. It's not unusual for a flight attendant to have an ear problem every year or two, right?

A. Not unusual.

Q. Okay. When you saw her in July of '93 --

A. Yes.

Q. -- she had complaints of another green discharge, just like she'd had a year and couple, three months earlier, right?

A. Right.

Q. But when you saw her, she didn't still have the green discharge, did she?

A. Well, I didn't make any mention of it.

Q. Right. And it would -- not that you have to write down every little thing that you see or do --

A. Yes.

Q. -- about a patient, but ordinarily if you had seen something, you would have written it down?

A. Usually.

Q. Usually. But the fact that you didn't write it down doesn't indicate to you that she hadn't had a green discharge?

A. Correct.

Q. Okay. So once -- and she had red, raw nasal passages, just like a year and three months earlier, right?

A. Right.

Q. And so here is another appearance of somebody who has an acute sinusitis caused by a bacterial infection, right?

A. Uh-huh.

Q. You didn't culture it?

A. No.

Q. Okay. It's not the practice to culture it at that point in time?

A. Correct.

Q. And, again, the bacteria could have come from anywhere?

A. Right.

Q. It's not unusual for you to have

patients come in and see you for sinus problems or nasal problems after they've been on a long flight --

A. Right.

Q. -- with a bacterial problem, is it?

A. Right.

Q. And that happens all the time here, doesn't it?

A. Yes.

Q. A lot of people fly in and out of Phoenix. Phoenix's Sky Harbor Airport is very busy?

A. Yes.

Q. And you get a lot of those patients, patients that travel a lot --

A. Yes.

Q. -- here in Scottsdale?

A. Yes.

Q. This is a -- it's that kind of community. There's a lot of air travel from the people who live here, right?

A. Yes.

Q. And after they have been on flights and been exposed to wherever they went and wherever they have come back to and the in-routes, it's not

unusual for them to pick up a bug, is it?

A. No.

Q. Okay. That was another acute sinusitis, right?

A. Right.

Q. Okay. And you prescribed an antibiotic for her?

A. Yes.

Q. Okay. So now you've treated her for three visits, and of those three visits, you've diagnosed her with a bacterial infection for two of them?

A. Yes.

Q. And you prescribed an antibiotic for her for both of them?

A. Yes.

Q. You next saw her on October 14th, 1993, right?

A. Yes.

Q. Now before she came to see you, she'd gone to see another doctor, right?

A. I don't know.

Q. Well, you performed a surgery with a Dr. Jack Friedland?

A. Yes.

Q. Had you ever performed a surgery with him before?

A. Yes.

Q. Frequently?

A. No.

Q. How many times do you think you'd done one with him before?

A. Several times. We worked together at a children's clinic, and he did the craniofacial abnormalities, and I would do ear tubes.

Q. All right. He's a plastic surgeon?

A. Yes.

Q. He does both reconstructive and cosmetic surgery?

A. Yes.

Q. And when you saw Ms. Janoff on October 14th, did you know that she'd already gone to Dr. Friedland?

A. At that time, I -- it must have been around that time, yes, that I knew he was -- I was aware she was seeing him.

Q. Did you know that she had already been to see him and already discussed surgery on her nose as well as other parts of her body at that point?

A. I don't -- I don't remember when I found out, but I -- I must have been aware of it because I wrote in my note that I was considering surgery.

Q. All right. But you didn't consider surgery until after you saw her on the 14th, right?

A. Correct.

Q. Right. I mean up to that point, you'd only seen her three times?

A. Yes.

Q. And two of those times, you'd diagnosed her with an acute bacterial infection, correct?

A. Right.

Q. So it's not your normal practice to propose surgery for somebody who's had three visits with you spread out over two years with just two bacterial -- with two bacterial, acute bacterial infections, is it?

A. Actually it's not that unusual if somebody -- if I think that there's something I can do to prevent the problem, if I know that they're going to continue to be -- to have whatever it is that's causing their symptoms.

Q. All right. So if you identify something that you think is going to help them to not have another episode of acute bacterial sinusitis,

you'll offer that to the patient if you think --

A. Yes.

Q. -- surgery will be of benefit?

A. Yes.

Q. All right. Did you know that -- well, strike that.

On the 14th, did you have any conversation with Dr. Friedland about why he was talking to Ms. Janoff about surgery on her nose?

A. No.

Q. To your knowledge, was he ever going to treat her for sinus problems with his surgery?

A. No.

Q. And that means to you that her anatomical problems, her deviated septum and her enlarged turbinates, were playing a real role in the development of her rhinitis, right?

A. It -- possibly.

Q. You wouldn't do the surgery -- I mean just a minute ago --

A. Yes.

Q. -- you told me that you wouldn't offer surgery to somebody unless you thought it was going to help them avoid whatever problems they were having from recurring in the future, right?

A. Right, but I didn't do the septoplasty.
Q. I know you didn't.
A. Right.
Q. But even though you didn't actually do it, you were in the room when it was being done?
A. Yes.
Q. You were part of the team?
A. Right.
Q. Okay. And if you thought that Dr. Friedland's surgery wasn't going to be of benefit to Ms. Janoff in terms of avoiding the recurrence of rhinitis and perhaps sinusitis, you wouldn't have gone along with it, would you?
A. Yeah, I thought that the -- the surgery would help some of the nasal congestion symptoms.
Q. Juries and I don't go --
A. Okay.
Q. -- to medical school.
A. Yes.
Q. So when you say "nasal congestion," symptoms --
A. The stuffy nose.
Q. That's part of her rhinitis/sinusitis problems?
A. No, the sinusitis symptoms were more the

pain and pressure and some of the earaches.

Q. Now up to this point, you never gave Ms. Janoff any pain medication of any kind, did you?

A. No.

Q. Okay. As a matter of fact, I don't think you've ever given her any pain medication?

A. No.

Q. Except perhaps after the surgery, you may have given her some. I don't know whether you did or not.

A. Yeah, probably.

Q. But as a regular part of her -- her treatment program, at any point in time, pain medication has not been part of it?

Q. How was -- in your opinion, how was the surgery performed by Dr. Friedland going to address rhinitis and the recurrence of rhinitis?

A. Well, by reducing the turbinates and straightening the septum, it may have alleviated some of the stuffiness.

Q. All right. Stuffiness is just a feeling, right?

A. No. It could be an actual physical blockage to breathing.

Q. Well, to breathing, but also it can cause the development of rhinitis; is that what you're saying?

A. No. The -- there is a couple of assumptions, and this may be where it -- I'm being a little bit misunderstood.

When I do -- I'm taking out my picture now just to show you. This schematic shows, you know, basically the anatomy in general terms with the septum being in the middle.

Now we talk about doing a septoplasty, changing the -- straightening the septum. Some people will do cosmetic procedures and say they're improving the breathing, and people assume most of the time that a deviated septum, you're doing it for -- to improve breathing.

Now rhinitis, when I use that term, there is a lot of different types of rhinitis. We try to sort it out by cause, allergic, vasomotor, and these type of things, but it means inflammation.

And with inflammation in the turbinates and in the nose, you can get symptoms, usually stuffiness, like when you have a cold.

Now when I recommended a -- considered

doing a septoplasty after reviewing the CAT scan, my goal was to reduce the sinus symptoms, so, in other words, I very often -- when I do a septoplasty, I am concentrating on the part of the septum that impacts the sinus drainage which may have nothing to do with whether the patient can breathe or not.

So I'm not really sure what Dr. Friedland was treating when he did the septoplasty.

Q. Okay. You didn't consult with Dr. Friedland before he made his recommendations on Ms. Janoff's surgery, correct?

A. No.

Q. Ms. Janoff indicated that she wanted both surgeries done at the same time, right?

A. Yes.

Q. But not then, right?

A. Oh, I don't know. I don't remember.

Q. When you did your surgery, you found polyps?

A. Yes.

Q. And were polyps contributing to the development of her sinusitis?

A. I believe they were.

Q. Nobody knows what causes polyps, do they?
A. No, there's probably a few reasons.
Q. But nobody knows what it is, and you can't look at a polyp and say: I know what caused you, right?
A. Exactly.
Q. But environmental tobacco smoke is not a known cause of polyps, is it?
A. As far as I know, no, I've never seen. .
Q. What role did her polyps play in the development of her sinusitis?
A. Well, according to the -- my operative note, I found polyps on the left sinus -- left ethmoid sinus, but her symptoms were on the right side.
Q. Your symptoms don't always go along with what's going on anatomically inside your body though, do they?
A. Not always.
Q. So what role did you conclude her polyps were playing in the development of her sinusitis?
A. I think that the polyps were a result of the recurrent rhinitis, sinusitis, and that that in turn led to blockage of the sinus, drainage pathway, and, you know -- and then it -- that just

became part of the cause of contributing to the recurrent sinusitis.

Q. So the role of the polyp in her ethmoid sinus was that it was blocking drainage and restricting the mucosal clearance?

A. That could be, yes.

Q. To resolve that, you took the polyps out?

A. Yes.

Q. You sent them to the lab?

A. Yes.

Q. And nothing about the lab report coming back on polyps told you anything about what caused the polyps, right?

A. Right.

Q. Things that you think contributed to the development of Ms. Janoff's sinusitis were secondhand smoke?

A. Yes.

Q. Dry air, bacteria, viruses, allergens?

A. I didn't think allergy was a big part.

Q. Not a big part?

A. Or any. I didn't recommend any allergy testing.

Q. Her anatomic abnormalities and her polyps, right?

A. Well, again, no, the polyps I found were on the opposite side of where most of her symptoms were.

Q. Well, did that mean to you that you could eliminate the polyps as a cause of her chronic sinusitis?

A. Her chronic sinusitis is now on the right side.

Q. Today?

A. Today.

Q. And --

A. And I was always treating her for right-sided symptoms.

Q. All right. And then is it your opinion today that the polyps that you found on the left ethmoid sinus played no role in the development of her sinusitis?

A. Yes.

Q. Okay. So the list of things that you think contributed to the development of her sinusitis were dry air, bacteria, viruses, and environmental tobacco smoke, and changes in air pressure on the aircraft, correct?

A. One thing I want to clarify, because we talk about environmental tobacco smoke, and that's

a big issue, and it's on my current patient intake form.

I ask about smoking and exposure to secondhand smoke. But in my treatment of Ms. Janoff, I didn't consider her exposed to secondhand smoke because it was such a high level of smoke, so I have her in a separate category.

Q. All by herself?

A. Along with all the other people on the plane, but, yes.

Q. Have you ever looked at -- do you know whether or not there are studies that have looked at actually scientifically tested flight attendants to see what their level of cigarette smoke exposure has been?

A. No.

Q. Do you know whether or not flight attendants have actually, by government studies, worn monitors to see what their level of exposure to secondhand smoke on board airplanes has been?

A. No.

Q. Do you know whether or not flight attendants have ever had blood drawn and their blood analyzed for cotinine, a metabolite of nicotine, to determine what their level of

exposure to secondhand smoke on board airplanes was?

A. No.

Q. In order to get a true scientific sense of what somebody's exposure to secondhand smoke and the role of the flight attendant on board airplanes would be, wouldn't you think that those would be good things for someone to look at?

A. It would be good from a scientific standpoint to know that, but unfortunately, in treating patients, it may not have much clinical significance.

Q. In the sense that you can't apply the information to how you care for the patient?

A. Well, in the sense that the -- not everybody will necessarily react the same way.

Q. All right.

A. In the sense that we set limits for levels of alcohol in the blood to determine whether somebody should drive, but that we have no way of determining how much somebody is impaired by that level.

Q. Right. Ms. Janoff was not a smoker during this period of her life, right?

A. Right.

Q. You know that she'd been a smoker for a short period of time in her life?
A. No.
Q. You didn't know that?
A. No.
Q. Okay.
All right. Your surgery was a success?
A. For a while.
Q. Okay. Just I'm -- you know what, I need to back up. Just so I got an answer to my question.
A. Yes.
Q. The things that you concluded played a role in the development of her chronic sinusitis were secondhand smoke, viruses, bacteria, dry air, and changes in air pressure, correct?
A. No, most -- I attributed most of her problem to the smoke exposure.
Q. I appreciate -- most -- you attributed --
A. I attributed her problems to the level of smoke exposure.
Q. I understand.
But you've testified previously --
A. Yes.
Q. -- and we can look at it if you want,

that in your opinion, dry air, bacteria, viruses and changes in air pressure also played a role, right?

A. I'd have to look at, you know, what I said exactly because those are things that play a role in sinusitis or rhinitis, and so I didn't mean to imply that I was -- that that was the -- what I felt in this case.

Q. Okay. You don't have your prior depositions with you, do you?

A. I can get them. They're in my office.

Q. You know that bacteria played a role, right, because you diagnosed her on two different occasions with a bacterial infection?

A. Right. The -- but the smoke -- I didn't say that the smoke caused bacteria.

Q. Correct.

A. Right.

Q. And you know that bacteria played a role in the development of her sinusitis?

A. Well, that's a definition of sinusitis, bacterial sinusitis. My clinical judgment is that the smoke caused rhinitis which caused inflammation which caused a blockage of the sinus, and then depending on the conditions of whether

there was bacteria present or any other factors, that sometimes that did lead to a bacterial infection which I treated.

Q. Let's go to Page 46, Line 2 through 10 -- 2 through 7 -- no, 2 through 10. I asked you the question -- let me just read it to you, and then I'll hand it to you.

A. Okay.

Q. You were asked -- I didn't ask you these questions -- are there any other factors that you attribute to causing or contributing to Ms. Janoff's sinusitis?

Answer: Well, I considered the possibility of the fact that other people on the plane might be sick or there might be viruses circulating and the fact that it was a dry atmosphere, so I considered those two.

Question: When you say you considered them, did you rule them out, or did you consider them as contributing?

Your answer was: I considered it as contributing.

Okay?

A. Okay. And what that means is I considered it. I did not answer the question

whether I ruled it out. So in order to -- when you say you considered them, did you rule them out, or did you consider them?

And I said: I considered them. I didn't say I ruled it out or ruled it in.

Q. Actually what you said then was: I considered them. I considered it as contributing, right?

Would you like to read that line?

A. Yes.

Okay. Let me see.

Okay.

Q. That's what you said, right?

A. That's what I said and --

Q. Let's go to another page.

A. -- it's the interpretation.

Q. All right. Let's go to another page.

A. Okay.

Q. Go to Page 183 --

A. Okay.

Q. -- lines 1 through 10. Do you remember being asked the question: Then I just want to be really clear. Is the absence of humidity either from living in Arizona or being on a plane, is that something you are still considering as a

possible cause for Ms. Janoff's condition and symptoms, or have you excluded that?

And your answer was: I think that low humidity and dryness, in her case, I think it just exacerbates her underlying problem. So it's not the complete cause of it, but it certainly doesn't help. And I've recommended different treatments for that.

Do you remember being asked that question and giving that answer?

A. Yes.

Q. Okay. Doctor, let's talk about allergies -- well, before we do that, Doctor, is it your opinion that had Ms. Janoff stopped being exposed to environmental tobacco smoke on board airplanes before she ever saw Dr. Weiss that that would have been a good thing for her?

A. I'm not really sure how long she had had problems. I would assume that it would have helped, but I don't know.

Q. All right. If she'd stopped being exposed to secondhand smoke on board airplanes because you hold the opinion that they played a role or it played a role in the development of her sinusitis, would it have been a good thing for her

medically if she had stopped being exposed to secondhand smoke after your first visit?

A. It would have been good.

Q. Sure. You can't tell, you can't turn back the hands of time now, you don't have a crystal ball, and tell us what her condition would be today if she had either stopped being exposed to ask secondhand smoke on board airplanes in, say, February of 1990, can you?

A. No.

Q. Nor can you say what her condition would be today? You don't have that crystal ball that would tell us what her condition would be today if she'd stopped being exposed to secondhand smoke on January 9th, 1992, right?

A. Right.

Q. In your opinion, if she'd never been exposed to secondhand smoke, can you tell us whether or not she wouldn't have developed sinusitis?

A. I don't know.

Q. No one knows that, do they?

A. Correct.

Q. It's not possible to know that, is it?

A. No.

Q. Let's talk about allergies. She has allergies today, right?

A. I only know of one allergy test that showed a minor allergy. I don't remember what it was. Another doctor had ordered it, but I did not consider her to have allergies.

Q. Right. The other doctor is Dr. Morgan?

A. Yes.

Q. And you've only seen one allergy testing report from him?

A. Yes.

Q. When Ms. Janoff saw you in April, did she tell you that she'd had more allergy testing?

A. I don't know what allergy testing you're referring to. I have --

Q. When she saw you --

A. April 9th, I have the results of some skin testing.

Q. In what year?

A. '02.

Q. So you do have some results of allergy testing in '02, right?

A. Yes.

Q. Have you looked at it?

A. Yes.

Q. So you're familiar with it?
A. Oh, yes.
Q. Then you know that it has positive results for -- well, strike that.
Have you seen a report from Dr. Morgan?
A. No, just the --
Q. Just the raw data?
A. Yes.
Q. You don't -- do you know that he has written a multipage report regarding his interpretation of the results of his allergy testing?
A. Yes, I have it. I have not looked at it.
Q. You've never looked at it?
A. No.
Q. All right. Do you know whether he made -- well, strike that.
A. I'm sorry.
Q. Let's go back to 1997.
A. I'm sorry. I have the 1997 report.
Q. But not the 2002 report?
A. Let me see if I do.
Yes. I have the report from April 9th.
Q. 2002?
A. Yes.

Q. That's the one you haven't read yet?
A. Not completely, no.
Q. You haven't read it at all; you're just glancing at it right now, right?
A. Yes. Well, I signed off on it, so I know I saw it originally. I just don't remember.
Q. All right. Would it have been a good idea for her to follow the treatment regimen for her allergies that he prescribed for her?
A. I don't know. I'm not -- I was not treating her for allergy, and I did not consider that to be a big component of her problem.
Q. All right. How about in 2002, did you review the results of the allergy testing? And I know we -- I know that you have not --
A. Yes.
Q. -- read his report --
A. Yes.
Q. -- in-depth?
A. Yes.
Q. Do you know if he's recommended more therapy for Ms. Janoff to deal with her allergies?
A. No, I don't know.
Q. Do you know if she's undergoing any therapy with Dr. Morgan for her allergies?

A. No.

Q. Do you know what modifications Ms. Janoff has made in her home because of her allergies?

A. Yes, I know that she's eliminated carpeting, put in filters, humidifiers.

Q. When did all that happen?

A. I'm not sure.

Q. Why did it happen?

A. Because she continues to have problems with sinusitis and rhinitis.

Q. Did you recommend she make those changes in her home?

A. I usually -- I just recommended the humidification, the irrigation.

Q. How about the modifications in her home, the changes of the carpeting and all that kind of air purification and all that?

A. No.

Q. Who did?

A. I'm not sure if anybody did or if she did it on her own.

Q. All right. There's no secondhand smoke in her home, is there?

A. No.

Q. So she didn't do it for purposes of eliminating secondhand smoke?

A. No. No. No.

Q. Dr. Morgan, have you ever spoken to him about her?

A. No, not about Ms. Janoff.

Q. Do allergists and otolaryngologists that are treating the same patient for the same condition, rhinitis, sinusitis, do they ever talk to one another?

A. Yes.

Q. Isn't that ordinarily what happens, don't they get together and design a joint treatment plan of some sort?

A. Sometimes.

Q. Any reason -- do you not like Dr. Morgan?

A. No, but my experience with allergy, since I used to administer allergy tests and immunotherapy is that in many cases it's not very helpful.

Q. All right. Allergies cause sinusitis though, don't they, they're one of the known causes?

A. Of rhinitis and sinusitis, yes.

Q. You don't know then to what extent

allergies have played a role in the development of Ms. Janoff's sinusitis and rhinitis, do you?

A. I think they played very little, if any, role.

Q. Okay. Do you know whether the allergists share that opinion?

A. No.

Q. Do you know how Ms. Janoff got to Dr. Morgan in the first place?

A. No.

Q. Do you know if that's the first allergist she's ever been to see?

A. I believe she saw Dr. Lanson many years ago.

Q. You learned that at your last deposition, right?

A. Yes.

Q. You didn't know it before that?

A. Well, I might have -- she might have mentioned it years ago, but I just didn't remember it.

Q. Have you ever seen any of the records that were prepared -- well, strike that.

Have you ever seen any of the records other than the test results from Dr. Morgan's

office?

A. From?

Q. For example, did you ever see the patient information sheet that Ms. Janoff filled out before she'd ever had any allergy testing at Dr. Morgan's office indicating what she was allergic to?

A. No.

Q. Can exposure to mold cause sinusitis?

A. There's some controversy about exactly what role mold plays, but I know I have seen many cases of allergic sinusitis due to mold.

Q. Do you know whether or not Dr. Morgan, in addition to a treatment plan, made any recommendations about what Ms. Janoff should avoid?

A. No.

Q. Her allergies are getting worse, aren't they, or do you know?

A. From what I remember, just from the most recent skin testing, there were a few reactions that hadn't shown up in the past.

Q. Minimal though to you?

A. Yes.

Q. With no consequence, really, in this patient?

A. I think that it's something that has developed since she's had the problem with the sinusitis.

Q. But they're minimal to you, aren't they?

A. Yes.

Q. Of no concern in terms of the treatment of this patient?

A. No. I think that what she's doing with the modifications to her environment and the -- the other treatments that we've -- we've done over the years is helpful.

Q. Do you know if she's getting allergy shots now?

A. No.

Q. Do you know if allergy shots have been recommended to her?

A. No.

Q. Ms. Janoff has become ill on any number of occasions for common everyday illnesses that your patients suffer from after she stopped flying on planes that had any secondhand smoke on them, correct?

A. Yes.

Q. She's been sick in January of 1996 when she was not flying on airplanes?

A. Uh-huh.
Q. Correct?
A. Yes.
Q. She came to see you for that illness, right?
A. Yes.
Q. She came to see you in March, March 10th of 1997 --
A. Yes.
Q. -- when she had not been exposed to cigarette smoke on board airplanes, she was on vacation, right?
On March 10th, 1997, you concluded that she was ill but not due to exposure to secondhand smoke, correct?
A. No, I didn't say that. She was -- she was flying as a passenger and she developed a problem.
Q. Do you know where she flew to?
A. I think -- was it Tahiti?
Q. I'm sorry, I didn't hear you.
A. I'm sorry, Tahiti. It was a long flight.
Q. To Tahiti and New Zealand?
A. I think so.

Q. And it's your recollection that she flew that flight round trip on a smoking flight voluntarily?

A. Yes.

Q. And it's your information --

A. I don't know if -- I didn't -- I'm sorry. I don't know if there was smoking on the plane, but I know that she had a problem.

Q. All right. And after the flight to and from Tahiti and New Zealand --

A. Yes.

Q. -- she came back to see you?

A. Yes.

Q. When she came back to see you, she said she was sick?

A. Yes.

Q. It's not unusual -- the flight to Tahiti alone is, what, 12 hours?

A. About that.

Q. And on to New Zealand is another 6?

A. Uh-huh. Yes.

Q. Yes?

Not unusual for people after -- and the time changes involved. Now we've flown literally, from here, we've flown almost halfway around the

world, haven't we?

A. Right.

Q. The time change, the effect on your body, can easily make someone become sick, can't it?

A. I suppose.

Q. Have you ever heard of your circadian sleep pattern?

A. Yes.

Q. If you disrupt that --

A. Yes.

Q. When people fly from here to Europe or from here to Tahiti and on to New Zealand --

A. Yes.

Q. -- disrupts your body altogether, doesn't it?

A. Yes.

Q. People get colds just as often there as they do on the ground, don't they?

A. It's not increased.

Q. They get it just as often, right?

A. Yes.

Q. You saw her on October 28th, 1998, and at that point you thought allergies were playing a role, right --

A. Yes.

Q. -- in her problem?

But you also must have thought that bacteria was playing a role because you put her on an antibiotic?

A. Right.

Q. And on April 21st, 2000, she got the flu, right?

A. Yes.

Q. Everybody gets the flu, don't they?

A. Not everybody, but it's common.

Q. Very common.

By the way, Mr. Williams asked you in his direct examination whether or not Ms. Janoff -- whether the "NKA" in your chart made reference to whether she had allergies, right?

A. Yes.

Q. When a doctor writes "NKA" in their chart or when a nurse does, that's a reference to known allergies to medications, right?

A. That is what my abbreviation stands for.

Q. Sure. I mean it's there as a big signal for you that if you're going to prescribe something for her, you need to know whether or not she's allergic to any medications, right?

A. Yes.
Q. Is there such a thing as nonsteroidal -- finish it for me, would you? What's the --
A. Anti-inflammatory.
Q. Yes.
A. Yes.
Q. Thank you very much. Nonsteroidal, anti-inflammatory drugs, right?
A. Yes.
Q. Do you know whether she's allergic to those?
A. No.
Q. Is that important for you as her treating physician to know?
A. Yes.
Q. May 9th, 2001, she had a sore throat; she had a cold, right?
A. May 9th?
Q. 9th, 2001. Maybe she didn't see you. Maybe she saw Dr. Morgan then.
A. Sore throat, cough.
Q. That's your visit?
A. Yes.
Q. She had a cold, right?
A. I said rhinitis.

Q. Is that different from a cold?
A. Could be. I didn't distinguish it.
Q. All right. So it could have been just a common cold?
A. Could have.
Q. Do you know that Ms. Janoff has a business?
A. Yes.
Q. What's the name of it?
A. I don't know.
Q. Do you know what she does in it?
A. Aromatherapy type --
Q. Bath salts?
A. Bath salts.
Q. She makes bath salts?
A. Yes.
Q. I don't use those personally, but it's mixing chemicals, correct?
A. Yes.
Q. And I understand she wears -- do you understand she wears a mask when she does that?
A. Yes.
Q. Do you know what kind of mask?
A. We talked about it. She wears a respirator.

Q. A respirator?
A. Yes.
Q. So to be around these chemicals, she wears a respirator?
A. Yes.
Q. All right. Have you recommended that, have you told her: You ought to wear a respirator around those chemicals?
A. I don't know if I told her, but it's usually a better filter than just a small --
Q. Surgical mask?
A. -- you know, dust mask.
Q. Those things don't work at all, do they?
A. Not for -- well, many things don't work for chemicals, but even fine particulates, they're not enough.
Q. All right. So you recommended she wear a respirator to get around those chemicals?
A. No, I didn't recommend it, but I think it's a good idea.
Q. Ms. Janoff, let's talk about her physical condition. Do you know whether she exercises regularly?
A. No.
Q. You understand that other doctors in

this case may reach different conclusions from yours as to what causes Ms. Janoff's problems?

A. Yes.

Q. It's not unusual for doctors to vary in opinion on the cause of an illness, right?

A. Correct.

Q. It's within the realm of opinions of medical physicians?

A. Yes.

Q. It's an inexact science, right?

A. We try to make it more exact, but there is a difference in opinion.

Q. Last time when Mr. Williams was asking you questions, he asked about Ms. Janoff's retirement from American Airlines. Do you know anything about that?

A. No.

Q. Did you ever indicate to Ms. Janoff that she needed to retire from American Airlines?

A. No.

Q. In your direct examination by Mr. Williams, you talked a bit about the cilia, the little hair-like structures that are attached to the cells that line the interior of the nose or portions --

A. Yes.

Q. -- of the interior of the nose and the sinuses?

A. Uh-huh.

Q. The cilia serve, or are thought to serve, a role in mucociliary clearance, right?

A. Yes.

Q. And the level to which their functioning is necessary for that process is debatable, isn't it?

A. Yes.

Q. Some people think it's extremely important, and some people think it may not be very important; there's a whole spectrum of thought within the medical community, isn't there?

A. Well, I take that back. There -- there is -- there is controversy and debate about the role or what is necessary in the ciliary function.

So, in other words, there are several conditions. We know that if the cilia don't work or in patients who have had extensive surgery where there's damage, then have problems that are due to the lack of cilia.

So I think -- I don't think there's a debate on the fact that the cilia are important.

Q. Okay. What affects cilia is debated though?

A. No. The studies that I have read are a little bit contradictory in the way cilia are affected by different things.

Q. Dry air affects cilia, doesn't it?

A. Yes.

Q. As a matter of fact, here in Arizona, dry air affects everybody's cilia, don't they -- doesn't it?

A. Probably.

Q. And the effect it has on the cilia here in Arizona is what? What happens to the cilia? What is the effect?

A. Well, I'm imagining it has an effect. A lot of the problems I see here I attribute to the dryness and drying of the mucous secretions; a lot of environmental things that I consider damage cilia, paralyze them, interfere with their function.

Q. Okay. Is there a way to test to see if people's cilia have been damaged?

A. You probably could do mucociliary clearance testing or electron microscopy.

Q. It's your opinion that as a result of

surgery you've performed on Ms. Janoff that her cilia have been affected in parts of her nasal passages, correct?

A. I wouldn't be surprised if the -- you know, the areas where surgery was performed that there is, you know, probably some loss of cilia.

Q. And just part of the process of the healing after a surgery, correct?

A. Yes.

Q. As a matter of fact, in your second surgery, part of what you did was to remove some adhesions, right?

A. Yes.

Q. And I don't know whether adhesions even form the type of cells that would bear cilia?

A. No. It's scar tissue.

Q. Scar tissue. So they wouldn't have cilia. So that would be an area of the nasal passage that might have had cilia before surgery but now doesn't, because, in the healing process, the cells that used to be there have been replaced with scar tissue?

A. Correct.

Q. Okay. But that's a pretty small area, right?

A. Yes.

Q. Whether or not Ms. Janoff's cilia have been affected by dry air or secondhand smoke as you think they may have been, has been untested, correct?

A. Yes.

Q. It could be tested. You could do it?

A. No, I could not do it.

Q. You couldn't do it?

A. No.

Q. What would you have to do?

A. I'm not sure. It's usually research tools that -- I have no idea how to test the cilia.

Q. Okay. In any event, it hasn't been done?

A. Correct.

Q. Okay. And if you were to test it today and if her cilia weren't functioning in some portion -- well, strike that.

You wouldn't expect the entire cilia in her entire nasal passages or sinuses to not to be functioning, right?

A. Correct.

Q. There might be some spot areas within the nasal passages or the sinuses that the cilia weren't working in some proper fashion; that's

what you'd be looking for?

A. No. One of the problems with testing is that it's a dynamic system which is constantly changing.

So, in other words, you wouldn't be able to test every single cell in the nose and sinus without, number one, damaging it, and, number two, at the time you test, it does not tell you, well, what was going on yesterday or the day before.

Q. All right. This testing takes the form, unless it's going to be in the shape of a biopsy --

A. Yes.

Q. -- the testing actually is just putting some saccharin in your nose and waiting until the patient says they taste it, right?

A. That's one test.

Q. All it does is tell you how long it takes?

A. Yes.

Q. And the problem is you don't have a baseline for that person, right?

A. Correct.

Q. So that really doesn't tell you a heck of a lot, does it?

A. No.

Q. And a biopsy, I'm not sure what you get out of the biopsy. You get to look at cilia under a microscope?

A. You could but only in that one spot that you biopsied.

Q. So that wouldn't tell you much either, would it?

A. No.

Q. So there's really no test either clinically or experimentally or from a research standpoint that would really tell us the answer to whether or not any given patient's cilia were damaged, right?

A. Not in a -- well, let me rephrase that. There have been studies that show that these things happen.

Now I'm not sure -- you have different hypotheses of why somebody has a problem, and I'm not sure that you need to know on a molecular level or a cellular level what's going on.

Q. Okay. And you've brought me full circle around to one other topic I want to talk about.

A. Okay.

Q. And that is, current research on the

causes and what is sinusitis --

A. Yes.

Q. -- is looking at it on a cellular level, isn't it?

A. Yes.

Q. That's where research is today, isn't it?

A. Yes.

Q. And the current research is indicating that for people who suffer from chronic sinusitis, that there seems to be an involvement of eosinophils in people who have chronic sinusitis, isn't it?

A. We don't know the role of the eosinophils because there are several conditions. It used to be attributed to allergy, where you would see a lot of nasal eosinophils in allergic patients.

We also have the nonallergic rhinitis with eosinophilia or Nares syndrome, and -- so we don't know what the significance of that is.

Q. Have you been reviewing the literature that's been published in Laryngoscope regarding eosinophilia or eosinophils fighting fungus as a cause of chronic sinusitis?

A. Yes.

Q. Doctor, I don't think -- well, are you scheduled to see Ms. Janoff any time in the near future?

A. No.

Q. You recently saw her in June of this year?

A. Yes.

Q. And what was her problem at that point?

A. Sinus headache.

Q. Did you identify the cause of her sinus headache?

A. Well, I felt at the time that she had rhinitis. She had some hyperemic, very red, congested tissues. I did not see an acute infection at that time, and I gave her an injection of a steroid.

Q. Okay. Any expectation of seeing her back any time soon? No return visit scheduled, I take it?

A. Right.

Q. Okay.

A. I do expect that she will be back.

Q. Some time?

A. Yes.

MR. REILLY: I don't think I have any

other questions, Doctor. Thank you very much.

REDIRECT EXAMINATION

BY MR. WILLIAMS:

Q. Mr. Reilly asked you concerning, he labeled it, chemicals that Mrs. Janoff uses in connection with her -- with her business.

I want you to assume, Doctor, that she uses only salts and oils. Do you consider those chemicals that could aggravate her condition?

A. I'm not sure what's in them, but most people have complained about a sensitivity to chemicals, like perfumes, on the basis that it stimulates the nerve endings --

(Thereupon, the playing of the videotaped deposition of MARIEL STROSCHEIN, M.D., was concluded.)

THE CLERK: Are we done, gentlemen?

MR. WILLIAMS: Yes.

THE CLERK: We're going to take a break right now while I get the judge.

What's the matter?

JUROR LE NOIR: I missed two minutes. Yes, starting at 2:20 and going back to

2:22:14, I really couldn't hear what was going on, and that was important to me.

THE CLERK: Any guidance, gentlemen?

MR. HUNTER: We're going to have to play it over.

THE VIDEOGRAPHER: I had no indication that nobody could hear.

JUROR LE NOIR: We're going to have to play it over again. We have to get rid of this (indicating).

MR. REILLY: We just need to go get the judge because we don't have the power to --

MR. WEINSTEIN: The judge is not here.

THE CLERK: We're going to go out now. Leave your pads there, and we'll discuss it.

(Whereupon, the jury exited the courtroom.)

MR. WEINSTEIN: What I suggest we do -- I know the judge has left --

MR. HUNTER: Martin, come here.

(A recess was taken at 5:25 p.m.)

(Back on the record at 5:29 p.m.)

MR. WEINSTEIN: The parties -- the parties have stipulated to playing back the portion of the -- this video deposition that

a juror, one juror mentioned she missed, and that is she stated that she missed 2:16 through.

MR. KODSI: 2:22.

MR. WEINSTEIN: 2:22, so the parties have agreed to play that back to the jury, and after that, there is about a page and a half of testimony that will be read to the jury by Mr. Williams, and then that will at least conclude this doctor's full testimony which both sides want to get over with.

That's stipulated, right? Somebody has got to say yes.

THE BAILIFF: Yes.

MR. UPSHAW: Yes. It doesn't preclude us from using the doctor's testimony in our case in chief.

THE BAILIFF: Okay. I'll bring the jury in.

(The bailiff left the courtroom.)

(The bailiff entered the courtroom.)

THE BAILIFF: Rise for the jury, please.

(Whereupon, the jury entered the courtroom.)

(Thereupon, the replaying of a section

of the videotaped deposition of MARIEL STROSCHEIN, M.D., was heard as follows:)

Q. As a matter of fact, here in Arizona, dry air affects everybody's cilia, don't they -- doesn't it?

A. Probably.

Q. And the effect it has on the cilia here in Arizona is what? What happens to the cilia? What is the effect?

A. Well, I'm imagining it has an effect. A lot of the problems I see here I attribute to the dryness and drying of the mucous secretions; a lot of environmental things that I consider damage cilia, paralyze them, interfere with their function.

Q. Okay. Is there a way to test to see if people's cilia have been damaged?

A. You probably could do mucociliary clearance testing or electron microscopy.

Q. It's your opinion that as a result of surgery you've performed on Ms. Janoff that her cilia have been affected in parts of her nasal passages, correct?

A. I wouldn't be surprised if the -- you know, the areas where surgery was performed that

there is, you know, probably some loss of cilia.

Q. And just part of the process of the healing after a surgery, correct?

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A. Yes.

Q. And I don't know whether adhesions even form the type of cells that would bear cilia?

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Q. Scar tissue. So they wouldn't have cilia. So that would be an area of the nasal passage that might have had cilia before surgery but now doesn't, because, in the healing process, the cells that used to be there have been replaced with scar tissue?

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Q. Okay. But that's a pretty small area, right?

A. Yes.

Q. Whether or not Ms. Janoff's cilia have been affected by dry air or secondhand smoke as you think they may have been, has been untested, correct?

A. Yes.
Q. It could be tested. You could do it?
A. No, I could not do it.
Q. You couldn't do it?
A. No.
Q. What would you have to do?
A. I'm not sure. It's usually research tools that -- I have no idea how to test the cilia.
Q. Okay. In any event, it hasn't been done?
A. Correct.
Q. Okay. And if you were to test it today and if her cilia weren't functioning in some portion -- well, strike that.

You wouldn't expect the entire cilia in her entire nasal passages or sinuses to not to be functioning, right?
A. Correct.
Q. There might be some spot areas within the nasal passages or the sinuses that the cilia weren't working in some proper fashion; that's what you'd be looking for?
A. No. One of the problems with testing is that it's a dynamic system which is constantly changing.

So, in other words, you wouldn't be able

to test every single cell in the nose and sinus without, number one, damaging it, and, number two, at the time you test, it does not tell you, well, what was going on yesterday or the day before.

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you biopsied.

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Q. And that is, current research on the causes and what is sinusitis --

A. Yes.

Q. -- is looking at it on a cellular level, isn't it?

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Q. That's where research is today, isn't it?

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We also have the nonallergic rhinitis with eosinophilia or Nares syndrome, and -- so we don't know what the significance of that is.

Q. Have you been reviewing the literature that's been published in Laryngoscope regarding eosinophilia or eosinophils fighting fungus as a cause of chronic sinusitis?

A. Yes.

Q. Doctor, I don't think -- well, are you scheduled --

(Thereupon, the playing of the videotaped deposition of MARIEL STROSCHEIN, M.D., was concluded.)

THE BAILIFF: Okay?

MR. WILLIAMS: We've got a little bit more.

THE CLERK: Go ahead.

MR. WILLIAMS: By agreement, the parties are going to read a section -- the redirect of Dr. Stroschein and a section, a couple pages from those depositions. The first questions are the redirect of me by Mr. Stroschein after Mr. Reilly's cross-examination. Page 292, Line 10.

(Whereupon, a portion of the deposition of MARIEL STROSCHEIN, M.D., was read to the jury as follows:)

REDIRECT EXAMINATION

BY MR. WILLIAMS:

Q. Mr. Reilly asked you concerning, he labeled it, chemicals that Mrs. Janoff uses in connection with her -- with her business.

I want you to assume, Doctor, that she uses only salts and oils. Do you consider those chemicals that could aggravate her condition?

A. I'm not sure what's in them, but most people have complained about a sensitivity to

chemicals, like perfumes, on the basis that it stimulates the nerve endings, and it can cause pain.

They might get a headache, but it doesn't -- as far as I know, you know, from what I've read, the people that have the chemical sensitivities, they usually have no physical finding.

Q. Okay.

A. So, in other words, we -- when we use ammonia salts for somebody who fainted, it's -- we're actually trying to make it hurt to stimulate them to wake up.

Q. Well, do you know if she has any chemical sensitivities?

A. She's never complained of anything.

Q. All right. Mr. Reilly covered the allergies, and I asked you several questions concerning allergies.

I believe you already testified on direct examination that during the course of your treatment of Ms. Janoff, you never felt that allergies played a role in her condition?

A. That's right.

Q. Is that right?

A. That's right.

Q. All right. If allergies did play a role in her condition, can you tell us how her -- how that would be manifested? Would it be seasonal? Would it be when she walks outside? What would you expect to see?

A. Most of the allergy problems that I see are, for the most part, seasonal. I have quite a few patients who exhibit symptoms constantly year-round, and that probably has to do with our climate and the fact that there's always grass, and some people have dust and mold allergies which might be present at all -- at all times, and those patients, again, have more chronic symptoms.

Q. Do you know if an individual can test positive for allergy testing, skin testing, and not manifest any symptoms?

A. Yes, I think that's possible.

Q. Has she ever come to you complaining of symptoms after working in her yard or being exposed to her plants and her grass and things like that around the house?

A. No.

Q. Have you recommended that she use rinses for her nose to moisturize her nose?

A. Yes.

Q. Is that something that someone with her condition would be expected to do to keep her nose moist?

A. Yes.

(Whereupon, the reading of a portion of the deposition of MARIEL STROSCHEIN, M.D., was concluded.)

MR. WILLIAMS: The next section is the deposition taken of Dr. Stroschein by Mr. Kodsi and Mr. McCue, and this is starting on Page 171 on June 25th of this year.

(Whereupon, a portion of the deposition of MARIEL STROSCHEIN, M.D., was read to the jury as follows:)

Q. That's in relation to this, specifically in this case. What do you base that opinion that exposure to secondhand smoke can cause or did, in fact, cause the plaintiff's condition?

A. Based on the fact that many times I treated her following an exposure to high levels of tobacco smoke, which was not environmental tobacco smoke, much higher concentrations, and the fact that most of the time I did not find evidence

of infection.

Subsequent allergy testing did not reveal any significant allergies and based on my findings and on examination.

Q. I think my question is a bit broader. What do you base your opinion that the exposure to secondhand smoke can cause this condition?

A. Well, just knowing the pathophysiology of rhinitis and sinusitis and knowing that any of the components of tobacco smoke can cause all the damage.

Q. You said components of cigarette smoke. Can you enumerate for us what those components are and what the effect is?

A. Well, I'm not an expert on tobacco smoke, but just from what I've learned back in medical school, there is carbon dioxide, nitrous oxide, tar, nicotine, and there is probably 1700 other chemicals, all of which cause changes to the cilia and cause a lot of other problems in the lining of the sinus, and this is well known.

Q. Again, forgive me, the phone is not good here. Did you say 1700 components in smoke that cause ciliary response?

A. No, I said there are 1700 compounds in

smoke that a number of which I know can cause damage to the cilia, but that's not the only effect. There are many others. I don't even know if they have all been studied.

Q. That's based on your recollection from what you learned in medical school?

A. Yes.

Q. As part of your preparation here, did you review any of those texts to refresh your recollection regarding that?

A. No.

Q. Do you remember which text you're referring to that helped you form that opinion?

A. Well, I went back to refresh my memory, and also in my ENT textbooks, they mention tobacco smoke as one of the toxins that can cause rhinitis and damage to the upper respiratory and digestive tract.

And it does not take -- the fact is that the components of tobacco smoke, secondhand smoke and smoking can cause cancer. The precursor to cancer is cellular damage. It's common knowledge.

(Whereupon, the reading of a portion of the deposition of MARIEL STROSCHEIN, M.D., was concluded.)

MR. WILLIAMS: That's it.

That's it.

THE CLERK: Okay. Ladies and gentlemen, leave your pads on your chairs. We're going to restart tomorrow at 9:30 sharp. Please be here on time --

JUROR LE NOIR: 9:45.

THE CLERK: -- in the jury room. Have a good night.

(Whereupon, the jury exited the courtroom.)

(Court was recessed at 5:45 p.m.)